

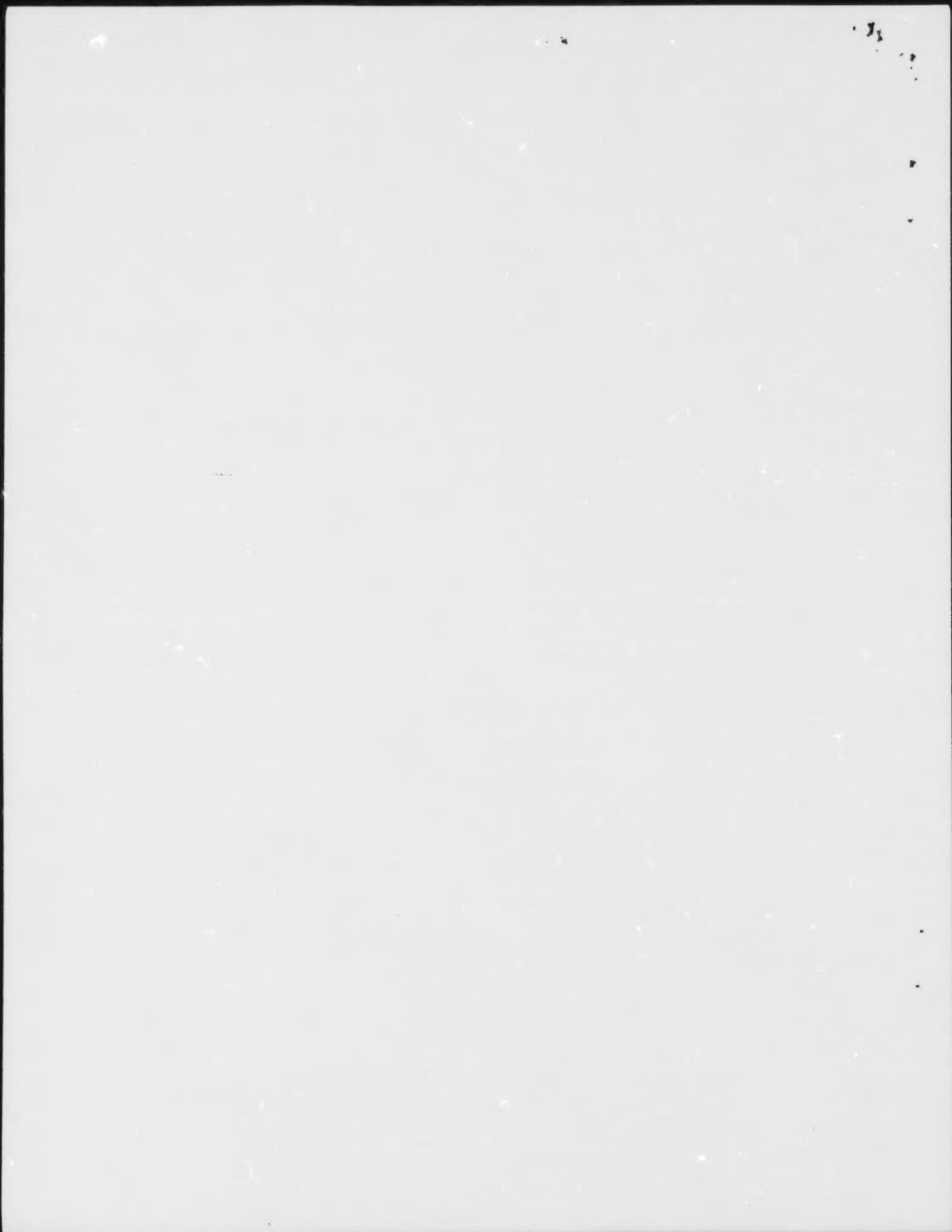
**A Review of Mental Health Services
in the British Columbia Corrections Branch:
Planning for Essential Services**

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A REVIEW OF MENTAL HEALTH SERVICES IN THE BRITISH COLUMBIA CORRECTIONS BRANCH

Table of Contents

Executive Summary	iv
Introduction	-1-
Defining "Mentally Disordered Offenders" and the MDO Categories	-3-
Correctional Centres in British Columbia	-5-
The Prevalence of Mentally Ill Inmates in British Columbia's Jails	-5-
The Review of 400 Inmates for this Report	-6-
Admissions and Transfers to British Columbia Adult Correctional Centres (1996-97 FY)	-12-
Issues Arising from the Review of Mental Health Services in B.C. Jails	-15-
Systems Issues	-15-
Issues to be Resolved at the Provincial Level	-15-
Issues to be Resolved at the Local (Institutional) Community Level	-20-
The Proposed Mental Health Plan for the BC Corrections Branch	-25-
The Focus of Mental Health Services in the Corrections Branch	-25-
Guiding Principles and Goals for Developing Mental Health Services in Jails	-25-
Elements of the Mental Health Plan	-27-
Intake Screening	-28-
Ongoing Monitoring/Screening of Inmates	-30-
Comprehensive Psychodiagnostic Assessment of MDOs	-32-
Mental Health Treatment	-32-
Gradual Post-Release Monitoring/Supervision and Continuity of Services	-34-
Program Evaluation	-35-
Staffing Needs for the Proposed Mental Health Services Plan	-36-
The Mental Health Team	-37-
Suicide and Self-Harm Identification and Management	-40-

Additional Considerations to be Addressed in the Mental Health Plan	-41-
Clinical Notes, Information Sharing, and Providing for Continuity of Information	-41-
Diversion of Mentally Ill Offenders	-43-
The Need for Treatment Programs/Facilities for Incarcerated MDOs	-43-
The Role of Corrections Officers and Other Staff in the Identification of and Management of MDOs	-44-
Conclusion: Priorities and Time Line	-46-
Appendix A: Schedule of Services:Review of Mental Health Services	-48-
Appendix B: A Review of the Relevant Literature	-50-
An Introduction to the Jail	-50-
The Rationale for Providing Mental Health Services in Correctional Facilities	-54-
Prevalence of Mental Illness Among Inmates	-54-
The Impact of Mental Disorder in Prisons and Jails	-60-
Legal Requirements for Mental Health Services in Correctional Facilities	-61-
Summary	-61-
References	-63-
Appendix C: Screening for Suicide Risk Among Jail Inmates:	
A Review of Risk Factors and Assessment Issues	-70-
Historical Variables	-71-
Clinical Factors	-73-
Suicide Risk Factors Specific to Inmates	-76-
Appendix D: Estimate of Suicide Risk (ESR)	-79-
Appendix E: British Columbia Corrections Branch	
Mental Health Services Review Screening Manual	-80-

Executive Summary

Overview of the Review of Mental Health Services in Corrections

- The system of delivering mental health services in correctional centres in British Columbia was reviewed between December, 1997 - March, 1998. In addition to visiting correctional centres, the review involved discussions with corrections administrators as well as senior personnel from ministries and agencies with responsibility for forensic and mental health services.
- The overall system of mental health service delivery is flawed as a result of a lack of an overall plan or focus for the provision of services to inmates with mental illness. In addition, there generally are few mandated minimal standards to guide the identification and delivery of services to mentally ill inmates.

Correctional Centres in British Columbia

- The prevalence rate of major mental disorders among jail inmates in the lower mainland of British Columbia, and throughout the province, is significantly higher than one would expect in the general population.
- The overall results of a review of 400 inmates drawn from the VPSC, the SPSC, the VIRCC, and the PGRCC show that a significant number of inmates across all institutions suffer from mental illness or symptoms of mental illness. Generally speaking, more inmates from VPSC, SPSC, and VIRCC require mental health services than those at PGRCC. In addition, the overall risk for suicide was low and quite consistent across institutions, with approximately 5-8 inmates (out of 100 per institution) presenting a risk of suicide or self-harm. Similarly, the mean level of risk of harm to others was low.

Issues Arising From the Review of Mental Health Services in B.C. Jails

- There is considerable variability among correctional institutions, with respect to the nature and extent of the mental health services they provide.
- There is a diffusion of responsibility for the development and implementation of mental health services in the Corrections Branch. Furthermore, there is very little centralized guidance provided to mental health professionals or to administrators. Finally, there is no identified mental health professional in the Branch who can communicate with other agencies and professionals at a professional level.

- Attention must be paid to the very pressing need of providing psychiatric care, including the administration of psychiatric medication, to acutely ill MDOs in the criminal justice system. Attention must be paid to this problem both at the provincial level and at the local level. Mechanisms must be developed to provide the much needed psychiatric treatment to inmates on an emergency and ongoing basis.

The Proposed Mental Health Plan for the BC Corrections Branch

- The emphasis of the plan for mental health services is on the six secure custody centres in the province (i.e., FRCC, KRCC, PGRCC, SPSC, VIRCC, and VPSC). If inmates' mental health needs can be identified upon admission to the jail, it is anticipated that a number of subsequent concerns can be diminished (e.g., the occurrence of unexpected manifestations of mental illness, inmates being classified or transferred to other institutions without knowing that they have mental health needs).
- The model for mental health services consists of six components: 1) intake screening; 2) ongoing monitoring/screening of inmates; 3) comprehensive psychodiagnostic assessment of MDOs; 4) mental health treatment; 5) gradual/post-release monitoring/supervision and continuity of services; and 6) research evaluation of the program.
- The mental health staff or "team" that is recommended for each of the secure custody facilities is necessarily interdisciplinary and should include a nurse, social worker/community liaison worker, psychologist, psychiatrist, intake interviewers, and administrative/clerical staff. Given the diversity of institutions, and the varying number of inmates admitted to them, the number of sessions or hours each of these people work may vary from institution to institution.

Projected Costs Associated with the Mental Health Teams

- Based on a preliminary review, the total costs for the mental health services at the six centres noted above is \$814,000. This exceeds the amount spent for psychological services in the 1997/98 Fiscal Year (2618 sessions = \$672,839); however, the additional costs are required for psychiatric nursing time and intake interviewer time. Ideally, staffing responsibilities and costs will be shared among Corrections, Forensic Psychiatric Services, and Mental Health Services. If this plan is adopted in some form, further planning could lead to cost containment and possible reductions. Such matters would require consultation at both the provincial and institutional level.

Suicide and Self-Harm Identification and Management

- The suicide rate in British Columbia's jails closely approximates that of the general population. In addition to the low number of suicides, relatively few incidents of self-harm by inmates are reported annually.

- Because of the difficulty predicting suicide, it is problematic to rely on any score derived from a scale. Instead, people who come into contact with inmates need to learn to identify the factors that relate to a risk of self-harm or suicide. In addition, it is useful for them to understand the relative importance of some of the factors for the inmate.
- Given the serious nature of self-harm or suicide, though, it is desirable to err on the side of caution. Therefore, care must be taken to classify and house inmates to ensure that their level or risk is managed. The development of a uniform suicide/self-harm policy is useful to provide some guidelines for identifying whether an inmate is at risk, and when that risk diminishes.

Additional Considerations to be Addressed in the Mental Health Plan

Clinical Notes, Information Sharing, and Providing for Continuity of Information

- While mental health professionals must log clinical notes in the healthcare files, information that is relevant to the management of an inmate must be logged in the progress file on a need-to-know basis.
- To facilitate the continuity of information about MDOs who are transferred between or among correctional institutions, it is possible to create a mental health field on the offender management computer system. Once inmates are screened, that fact would be indicated on the system. If the inmate was identified as being in need of mental health services a "mental health alert" could be recorded. This would alert corrections staff that the inmate may have mental health problems. The on-line information also would be of use to help intake interviewers – and other mental health care staff – decide whether an inmate who is "newly" admitted or who is transferred in requires a very cursory or more extensive screen.

Diversion of Mentally Ill Offenders

- Many mentally ill inmates do not commit violent crimes, and they cycle back and forth between the criminal justice and mental health systems. Systematic attention must be paid to developing programs to "divert" dually diagnosed mentally ill offenders out of the criminal justice system, either at some point before arrest, or following arrest once they have been screened for mental illness and risk.

The Need for Treatment Programs/Facilities for Incarcerated MDOs

- Treatment programs and/or facilities must be available to treat MDOs while they are incarcerated. There is a need for the Provincial MDO Committee to consider expanding such treatment programs to accommodate the needs of offenders who are mentally ill, but

who are not so acutely mentally ill that they require certification and treatment in a secure hospital unit.

- Given the limited resources available, it is important NOT to expect every sentenced facility to provide mental health treatment to MDOs. Rather, it makes sense to transfer MDOs to facilities which have specialized programs to accommodate their needs.

The Role of Corrections Officers and Other Staff in the Identification of and Management of MDOs

- Concerted efforts must be made to involve line staff – particularly correctional officers – in the identification and management of mentally ill offenders.
- There is a need to provide further training to staff who work with MDOs either in more advanced programs at the Justice Institute or in in-house training that can be tailored to the specific needs and situation in the particular institution in which the officers work. The latter option is likely better but, again, would require resources for training.

Priorities and Recommendations:

1. (Re-)Establish the Provincial Mentally Disordered Offender Committee.
2. Establish a Mental Health Services portfolio in Corrections that parallels the Health portfolio; this would include the appointment of a Director of Mental Health Services.
3. Wherever possible within secure custody institutions establish a mental health team on a *pro tem* basis to begin to facilitate the mental health plan at the centre.
4. Negotiate a provincial-wide agreement between the Corrections Branch, Forensic Psychiatric Services, and Mental Health Services to: (1) clarify the nature and extent of each agency's responsibility for mentally ill offenders and (2) to set in place the minimum standards of care necessary to address the needs of mentally ill offenders when incarcerated in correctional centres and upon discharge to the community.
5. Work with provincial agencies and local psychiatric facilities to make arrangements for the transfer and provision of care for acutely mentally ill offenders who are certifiable under the Mental Health Act and who require psychiatric treatment.
6. Establish Mental Disorder Committees at the local institutional/regional level to: (1) clarify the nature and extent of each agency's responsibility for mentally ill offenders and (2) to set in place policies and procedures for detailing how the provincially-established minimum standards will be met at the local level.

7. Establish a mental health team and implement the mental health plan components at each of the secure institutions (with the following components: 1) intake screening; 2) ongoing monitoring/screening of inmates; 3) comprehensive psychodiagnostic assessment of MDOs; 4) mental health treatment; 5) gradual/post-release monitoring/supervision and continuity of services; and 6) research evaluation of the program).
8. Implement the use of a suicide risk assessment protocol, such as the ESR, as part of the admission process to the correctional centres. Train line staff, healthcare staff, and mental health professionals to understand and identify the risk factors associated with suicide and self-harm.
9. Review and develop a uniform policy governing the identification and management of inmates at risk for self-harm and suicide.
10. Develop an on-line system of maintaining information about whether inmates were screened for mental illness and whether the inmate is in need of mental health services. Establish and reaffirm information sharing and record keeping in the health files and progress logs.
11. Review the need for and establish or further develop treatment programs and/or facilities that will be available to treat MDOs when they incarcerated (e.g., using a model such as that which is available on a limited basis at institutions like Ford Mountain).
12. Work with affected agencies and Crown Counsel to establish protocols for diverting mentally ill offenders out of the criminal justice system when appropriate and to provide alternative community-based residential treatment programs for mentally ill offenders at regional levels.
13. The Director of Mental Health Services should work with Corrections Administrators to develop mechanisms for increasing the involvement of corrections officers in the identification and management of mentally ill offenders.
14. Establish and provide training to corrections officers and other staff regarding the identification and management of mentally ill offenders. The training should not only occur at the Justice Institute, but at the institutional level where the material may be geared toward the nature of offenders in the institution and the type of mental health services provided there.



A REVIEW OF MENTAL HEALTH SERVICES IN THE BRITISH COLUMBIA CORRECTIONS BRANCH

Introduction

From December, 1997 through March, 1998, I had the unique opportunity of reviewing the system of delivering mental health services in correctional centres in British Columbia (see Appendix A for the Schedule of Services for the Review).¹ To facilitate this project, I reviewed the literature on identifying and treating mentally ill people in jails (see Appendix B). I visited all but one of the secure custody institutions in British Columbia, as well as three of the medium security facilities, and some of the camps. In those institutions, I had the good fortune of meeting with countless officers, administrators, nurses, physicians, psychiatrists, psychologists, and social workers. In addition, I met with administrators from the Corrections Branch, Mental Health Services, and Forensic Psychiatric Services. I also designed and implemented a review of psychiatric symptoms, risk factors for self-harm and harm to others, and intellectual impairment among a sample of 400 inmates drawn from four correctional centres in the Province (i.e., Prince George Regional Correctional Centre, Surrey Pretrial Services Centre, Vancouver Pretrial Services Centre, and Vancouver Island Regional Correctional Centre). This experience was profound and illuminating.

Although it almost goes without saying, British Columbia is a large and diverse province, with a very heterogeneous population. This fact became amplified, repeatedly, as I toured the facilities around the province. Similarly, the many institutions within adult corrections also are very diverse, each serving a somewhat unique purpose. Taken together, after visiting the centres and considering the matters to be reviewed in this document, I was left with one overwhelming conclusion. The system of mental health service delivery in the Corrections Branch lacks an overarching plan or focus. Indeed, there are no minimum standards of care that have been uniformly applied across institutions. Moreover, I was informed – repeatedly – that situations exist in which mentally ill inmates cannot receive the care they require. This is not to say that I was not impressed with the care, dedication and skill demonstrated by so many people with whom I had come into contact. Indeed, I saw several examples of innovative programs and service delivery models that appeared to be quite effective in identifying, treating, and providing community care to inmates with mental illness. The difficulty, though, lies in the lack of overall standards or plans for identifying mentally ill inmates and for delivering mental health services to them in jails, and for providing appropriate care in the community. Furthermore, the individual programs and projects that do seem to work well do so in spite of, rather than because of, any central plan. Although there have been attempts at setting standards in the past, these have been met with little success.

At the outset, I wish to emphasize that this report will not evaluate the Corrections Branch or particular institutions. Instead, the goal of this report is to address the issues and

¹In addition to the current review, a similar review was conducted of the psychological services provided at the Burnaby Correctional Centre for Women (Ogloff & Nicholls, 1997).

concerns I encountered during my review. In this report, I begin with a brief overview of the correctional centres in British Columbia, including a discussion of the prevalence of mentally ill inmates. I then present the results of the review of 400 inmates drawn from four correctional centres in the Province (i.e., Prince George Regional Correctional Centre, Surrey Pretrial Services Centre, Vancouver Pretrial Services Centre, and Vancouver Island Regional Correctional Centre). I next provide data concerning admissions and transfers to institutions. After presenting this overview material, I identify the issues that arose from the review and, where possible, provide some solutions for addressing those issues. Following this background material, I will provide an overall mental health services plan for the Corrections Branch. This plan will take into account both systems issues and service delivery issues.

To the extent possible, the review will present the level of detail necessary to address the practical concerns to be considered for implementation. However, it must be cautioned that this review and the plan proposed is intended to be considered a starting point in the development of a feasible mental health services plan. As will become clear, there is no quick solution. The issues that arose from the review are complex and multifaceted. The rather than providing a series of "quick-fixes," the plan will provide a discussion of the many issues that must be addressed in the final plan that is realized.

I would like to take the opportunity in this introduction to highlight the appendices that are attached to this report. The information contained in the appendices is important and will be of great interest to some readers. Appendix A is the schedule of services for the review of mental health services conducted. It sets out the scope of work that was requested. Appendix B presents a review of the relevant literature available on the topic of mentally ill offenders. This material will be of use to provide a context for the material presented in this report. It will prove particularly useful for those mental health professionals and others who are less familiar with the subject matter. Appendix C provides a review of the risk factors and assessment issues related to suicide in jails. This material is important since it is important for all personnel who come into contact with inmates to have an understanding of the factors that have been found to relate to risk for suicide among jail inmates. Appendix D presents the Estimate of Suicide Risk (ESR: Polvi, 1997). This instrument was designed for use in Canadian correctional facilities. Although it has not yet been validated, the instrument shows great promise and is useful since it requires those who administer it to review the factors that have been found to relate – empirically – to risk for suicide. Finally, Appendix E consists of the screening manual employed in the review of the 400 inmates in this report. In some form, as will be discussed later in this report, similar information should be collected on all inmates entering provincial correctional facilities.

As a final comment, I would like to note that given the scope of this review, and the complex subject matter that is its focus, some readers undoubtedly will have some concerns about what I write. It is in this regard that I must emphasize how very open I am to ongoing input into the development of the mental health services plan that ultimately will be implemented in the Corrections Branch. I turn now to a brief discussion of the operational definition of "mentally disordered offenders" and the MDO categories.

Defining "Mentally Disordered Offenders" and the MDO Categories

Given the potentially broad and ambiguous term, the definition of Mentally Disordered Offender (MDO) adopted for use in this report was based on that developed by B.C. Corrections MDO Committee (1991) as follows:

MDO's are those persons in the criminal justice system who require clinical intervention to address their behavioural and mental health problems. MDO's include a range of persons, from those who are clearly certifiable under the Mental Health Act to those who have situational disturbances. Mentally handicapped persons are not categorized ... [as MDO's] ... unless they have a concomitant disorder.

This definition is broad enough to include all inmates who suffer from behavioural and mental health problems, while not being so broad as to include all inmates. Thus, those inmates who have behavioural problems, but who do not exhibit symptoms of mental illness, are excluded from our definition. However, those inmates suffering a psychiatric crisis would still be included in the definition. Another noteworthy point is that although the term MDO incorporates the word offender, it should be noted that obviously prior to conviction all persons are presumed to be innocent before the law.

It may be useful to paraphrase the five categories of MDO's that have been articulated by the B.C. Corrections MDO Committee, and adopted for use in this plan:

Category I - Certifiable - People who suffer from severe psychotic illnesses characterized by thought disorders, delusions, hallucinations, or profound abnormalities of mood (i.e., out of touch with reality); and who present a threat to self or others; may or may not be found fit (competent) to stand trial; may or may not be competent to give informed consent.

Category II - Mentally Ill, Not Certifiable - Persons who are seriously disturbed and show clear signs of mental illness, but do not present an immediate risk to self or others; most would be fit to stand trial and competent to make informed consent decisions.

Category III - Dysfunctional but Not Seriously Mentally Ill - People who may show only borderline features of mental illness, but who may have multiple problems that aggravate their situations and disturb others (e.g., organic disorders, substance abuse, borderline mental handicap); these people may be considered "dysfunctional" to the extent that they may display an array of problems including mood disorders, lack of control, emotional lability, and suicidal ideation.

Category IV - Situational/Short Term Disorders - These people are not seriously

disturbed (i.e., they lack the features of a major mental illness), but are generally reacting to some pressure in their lives; they develop acute adjustment problems that may be reactive in nature and are generally treatable; their main symptoms are likely to be anxiety or depression, and while they are not likely to pose a threat to others, they may present, for short periods, a high risk of danger to themselves.

Category V - Intellectually Challenged - This category is reserved for people who are intellectually challenged (i.e., deficiencies in intellectual and/or adaptive functioning (e.g., mentally retarded)).

These categories may be particularly useful insofar as those inmates who meet the criteria for each category may require unique mental health services. They are of particular use to corrections officers because the focus is on the extent to which each category affects an inmates functioning. The categories will be useful for identifying those inmates most in need of immediate treatment and to develop treatment tiers of graduated intensity. As inmates are screened in correctional centres these categories also will be useful for maintaining records about the number of inmates who fall into each of the categories.

To the extent that inmates fit into the above categories, they will require more or less intense treatment, their prognoses will vary, and they will be more or less likely to benefit from community-based intervention.

Correctional Centres in British Columbia

In this section, I will provide some of the necessary information to provide a background for the material that will follow.

The Prevalence of Mentally Ill Inmates in British Columbia's Jails

The prevalence of mental illness among offenders, generally, is reviewed in the background material presented in Appendix B of this report. Relatively little is known about the actual prevalence of mental illness among inmates in the provincial jails in British Columbia. Available health care statistics show that 101 inmates were certified under the Mental Health Act in the 1997-98 fiscal year. The comparable figures were 54 in 1996-97 and 61 in 1995-96. While these numbers appear small, when compared to the general population, inmates in 1997-98 were approximately 16 times more likely to be certified than those people in the general population. This provides a very general indication of the degree of mental illness for those inmates who are most seriously ill. Of course, most inmates with mental illness are not certifiable, and must be housed and managed in the provincial correctional centres.

Apart from the information provided above, two formal studies exist concerning male offenders. In the first, Roesch (1995) reported the prevalence of mental illness among inmates at the Vancouver Pretrial Services Centre (VPSC). A representative sample of 192 inmates were assessed using the Diagnostic Interview Schedule (DIS: Robins, Helzer, Croughan, & Radcliff, 1981). Table 2 below represents the prevalence of psychiatric diagnoses among inmates at the VPSC.

Table 2. Prevalence of DIS/DSM-III Diagnoses Among Admissions to the Vancouver Pretrial Services Centre

DIS/DSM-III Diagnosis	Prevalence (% of total admissions)
Major Mental Disorders	15.6
1. Cognitive Impairment (Severe)	0.5
2. Schizophrenic Disorders	4.9
3. Major Affective Disorders	10.1
Substance Use Disorders	85.9
1. Alcohol Abuse/Dependence	77.6
2. Drug Use Disorders	63.7
Other Mental Disorders	88.0
1. Anxiety Disorders	41.1
2. Dysthymic Disorders	7.2
3. Somatization Disorder	0.7
4. Eating Disorders (Bulimia)	0.3
5. Sexual Disorders	27.0
6. Antisocial Personality Disorder	64.3

Source: Roesch, R. (1995). Mental health intervention in jails. In G. Davies, S. Lloyd-Bostock, M. McMurran, & C. Wilson (Eds.), Psychology, law, and criminal justice (pp. 520-531). New York: Walter de Gruyter.

In a second study, 130 inmates held at the Surrey Pretrial Services Centre (SPSC) between March, 1994 - August, 1995 were randomly selected to be contacted and were administered the routine intake mental health screening, as well as the Structured Clinical Interview for DSM-III-R (SCID)(Ogloff, 1996). Table 3 presents the prevalence of mental disorders and substance abuse disorders among those people admitted to the SPSC.

Table 3. Prevalence of DSM-III-R Diagnoses Among Admissions to the Surrey Pretrial Services Centre

DSM-III-R Diagnosis	Prevalence (% of total admissions)
Major Mental Disorders	19.7
1. Bipolar Affective Disorder	0.8
2. Major Depression	15.7
3. Psychotic Disorder NOS	0.8
4. Schizoaffective Disorder	2.4
Substance Use Disorders	60.9
1. Alcohol	24.0
2. Cannabis	16.5
3. Cocaine	10.2
4. Hallucinogens	1.6
5. Opioids	5.5
6. Sedative Hypnotics	3.1
7. Polydrug	15.0

Source: Ogloff, J. R. P. (1996, July). *The Surrey Pretrial Mental Health Program: Community component evaluation*. British Columbia Forensic Psychiatric Services Commission.

Taken together, Tables 1 and 2 clearly show that the prevalence rate of major mental disorders among jail inmates in the lower mainland of British Columbia is significantly higher than would be found in the general population. For example, those inmates who were suffering from a psychotic illness varied from 3%-5% – this is several times higher than the comparable prevalence that would be found in the general population (approximately 1%). An additional 10%-15% of inmates suffered from a major affective disorder, such as major depression. Again, this rate is several times higher than that which would be found in the general population. Furthermore, the rate of substance use disorders among the inmates is nothing short of alarming.

The Review of 400 Inmates for this Report

In addition to the data presented in Tables 1 and 2, data were collected for this review to obtain systematic information about the prevalence of psychiatric symptoms, risk factors for self-harm (including suicide) and harm to others, and intellectual impairment. A sample of 400 inmates drawn from four correctional centres in the Province (i.e., Prince George Regional

Correctional Centre, Surrey Pretrial Services Centre, Vancouver Pretrial Services Centre, and Vancouver Island Regional Correctional Centre) was used for this purpose. The information was collected to provide some very general information about the mental health of inmates in the four institutions selected. Although a considerable amount of data were collected, it is beyond the scope of this review to provide much more than the "basic findings" as they relate to mental illness. Thus, the salient findings will be presented in this section to show the extent of mental illness, self-harm, risk of harm to others, and intellectual functioning among inmates and to compare that information across the four institutions.

Table 3
Number of Inmates In Each Mental Disorder Category By Institution²

Institution	MDO 1	MDO 2	MDO 3	MDO 4	MDO 5	No MDO
PGRCC	0	3	1	4	5	84
SPSC	1	5	34	12	0	46
VIRCC	2	11	4	10	2	70
VPSC	1	6	49	11	1	30
Total	4 (1%)	25 (6%)	88 (22%)	37 (9%)	8 (2%)	230 (60%)

As the data above show, approximately 1% of inmates suffer from severe psychotic illnesses. An addition 6% are seriously ill but not likely certifiable under the Mental Health Act. If one looks at the data above for SPSC and VPSC, an alarming number of inmates fall into Category III – that is, they display borderline features of mental illness and have multiple problems that aggravate their situations (e.g., organic disorders, substance abuse, etc.). Taken together, the above information provides further support for the contention that a significant percentage of inmates are mentally ill and require services for their mental illness. Indeed, 40% of all inmates screened were identified as fitting into one of the five categories on mental disorder.

Comparing mental illness across centres, it is apparent that, as a group, more people at SPSC and VPSC are "disturbed" than those at VIRCC or PGRCC. However, if we only consider categories I and II, the prevalence of mental illness appears highest at VIRCC, followed by VPSC and SPSC, and, finally, PGRCC.

²The MDO Categories are explained on pages 3-4 of this report.

Apart from relying on the data from the MDO categories above, inmates were rated on the Brief Psychiatric Rating Scale (BPRS; Overall & Gorham, 1962), a measure designed to identify the extent to which individuals display 24 symptoms of mental illness. The BPRS has been used in the Surrey Pretrial Services Centre Mental Health Program since 1991. Research by Brown (1996) showed that results from the BPRS were positively related to factors such as aggression, anxiety, and withdrawal by inmates. A more expanded discussion of those results is beyond the scope of this report, suffice it to say, though, that in addition to providing basic information about inmates' symptoms of mental illness, the BPRS can be useful for helping with classification and management recommendations.

The results from the BPRS are presented in Table 4 below.

Table 4
Brief Psychiatric Rating Scores by Institution

Institution	Mean BPRS Score	Standard Deviation	Range
PGRCC	33.31	8.19	24 - 68
SPSC	26.25	4.45	24 - 42
VIRCC	36.78	10.68	24 - 64
VPSC	28.9	7.97	24 - 72
Overall	31.31	9.05	24 - 72

The data from the BPRS are quite consistent with those presented in Table 3 regarding the MDO categories. Indeed, the mean BPRS scores were highest for inmates at VIRCC. Interestingly, though, the mean BPRS scores were higher at PGRCC than for either SPSC or VPSC. It is difficult to explain the results; however, upon reviewing the specific data for each inmate, it appears that while the overall BPRS scores are higher, the most seriously ill people are at VIRCC, VPSC, and SPSC. What these data confirm, though, is that while more seriously ill inmates are found in the jails in large urban areas, there still are inmates in smaller cities who display a number of symptoms of mental illness.

Table 5

Inmate Management Recommendations

Institution	Monitor/Reassess	Segregation	Suicide Watch
PGRCC	4	1	1
SPSC	24	1	0
VIRCC	4	2	2
VPSC	23	2	7
Overall	55	6	10

Table 5 presents the management/classification recommendations that were made by the intake interviewers at each institution. These data show that a higher number of inmates at SPSC and VPSC would be referred to a mental health team for monitoring and reassessment. Relatively few inmates would be recommended for segregation and, apart from VPSC, the number of people recommended for "suicide watch" is low.

Table 6

Level of Risk for Suicide/Self-Harm

Institution	Low	Medium	High
PGRCC	95	5	0
SPSC	97	2	0
VIRCC	92	5	3
VPSC	92	3	3
Overall	376 (94.7%)	15 (3.8%)	6 (1.5%)

Table 7

Mean Estimate of Suicide Risk Scores by Institution

Institution	Mean ESR Scores	Standard Deviation	Range
PGRCC	10.07	4.27	35878
SPSC	6.75	4.94	0
VIRCC	10.05	4.16	35821
VPSC	9.66	6.35	35823
Overall	9.21	5.87	0

The data presented in Tables 6 and 7 above show that between 5%-8% of inmates were identified as being at a "medium" or "high" level of risk. The overall degree of risk for suicide as measured by the ESR was low to moderate, and quite consistent across institutions. It should be emphasized that because of the small number of inmates who were identified as being at risk for suicide, it is difficult and probably not valid to draw any conclusions regarding the small differences across institutions.

The final area of results that will be discussed here is the level of risk of harm to others that inmates demonstrated. To assess risk of harm to others, the screeners used the "Historical" scale of the HCR-20 (Webster, Douglas, Hart, & Eaves, 1997) to indicate the extent to which inmates possessed those factors that relate to risk of harm to others (i.e., previous violence, young age at first violent incident, relationship stability, employment problems, substance use problems, major mental illness, psychopathy, early maladjustment, personality disorder, and prior supervision failure). The maximum possible score is 20; however, most of the inmates could not be rated on two of the items (i.e., psychopathy and personality disorder). This information is based on self-report and it would be ideal to follow-up the individuals to determine whether the scores on the H scale relate to actual incidents in the jails and in the community.

Table 8
Mean "H" Scores from the HCR-20

Institution	Mean H Scores	Standard Deviation	Range
PGRCC	7.84	3.32	0
SPSC	5.09	3.89	0
VIRCC	6.59	2.54	0
VPSC	5.81	3.66	0
Overall	6.34	3.53	0

The above results show that, like risk for suicide, the overall risk of harm to others is low. However, the general risk of harm to others was significantly greater for inmates at PGRCC than for those at any other institution.

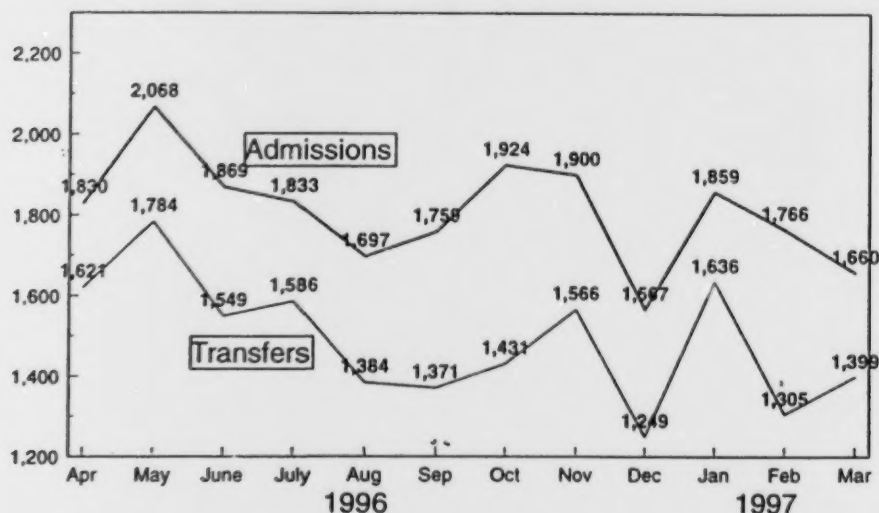
The overall results show that a significant number of inmates across all institutions suffer from mental illness or symptoms of mental illness. Generally speaking, more inmates from VPSC, SPSC, and VIRCC require mental health services than those at PGRCC. In addition, the overall risk for suicide was low and quite consistent across institutions. Similarly, the mean level of risk of harm to others was low.

Over time, it would be useful to follow-up the 400 people sampled to determine whether the indicators of mental illness, risk of self-harm, and risk of harm to others are valid for these samples of offenders.

Admissions and Transfers to British Columbia Adult Correctional Centres (1996-97 FY)

To facilitate the development of the mental health services plan, it is necessary to obtain an accurate indication of the number of admissions and transfers of inmates to British Columbia correctional centres. This information will be presented in this section.³ Figure 1 provides the total admissions and transfers by month for the 1996-1997 fiscal year for the entire Corrections Branch.

Figure 1
Total Admissions and Transfers
by Month for the 1996/97 Fiscal Year



As Figure 1 shows, there is considerable monthly variation in the number of admissions and transfers. In total, for the 1996-1997 fiscal year, there were 21,732 new admissions and 17,881 transfers into correctional facilities.

The information that follows will provide data regarding the number of admissions and transfers to the correctional centres in British Columbia which have new admissions. These data are useful to obtain a "snapshot" of admission patterns across the correctional centres. In addition, though, the data will prove useful for considering the feasibility and costs that are associated with implementing a plan for screening incoming inmates to the Branch to identify those who are mentally ill and in need of services.

³I am particularly grateful to Mike Kotyk of the Corrections Branch who assisted me by providing me with the data necessary to compile the figures in this section of the report.

Figure 2
Admissions and Transfers to BCCW by Month for the 1996/97 Fiscal Year

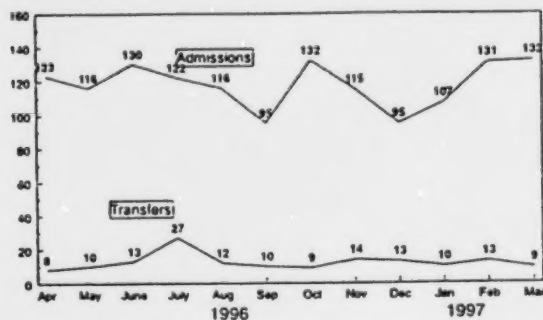


Figure 3
Admissions and Transfers to FRCC by Month for the 1996/97 Fiscal Year

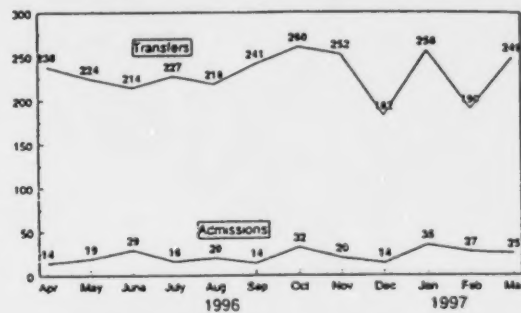


Figure 4
Admissions and Transfers to KRCC by Month for the 1996/97 Fiscal Year

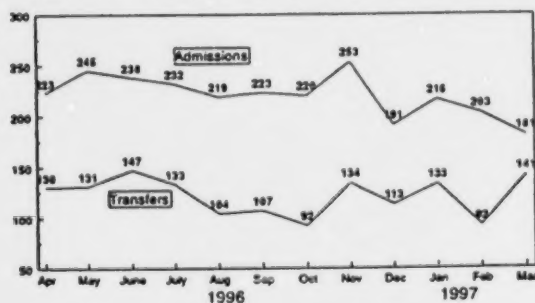


Figure 5
Admissions and Transfers to PGRCC by Month for the 1996/97 Fiscal Year

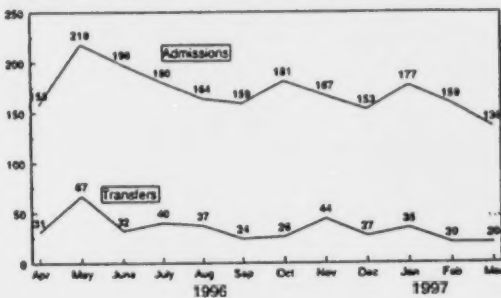


Figure 6
Admissions and Transfers to SPSC by Month for the 1996/97 Fiscal Year

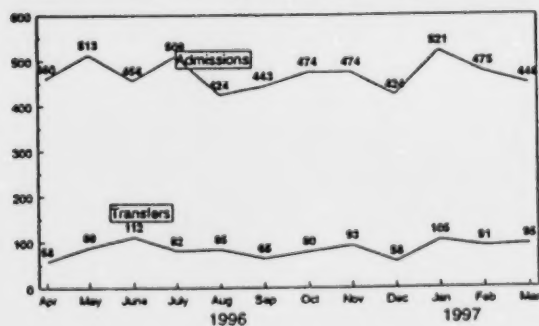


Figure 7
Admissions and Transfers to VRCC by Month for the 1996/97 Fiscal Year

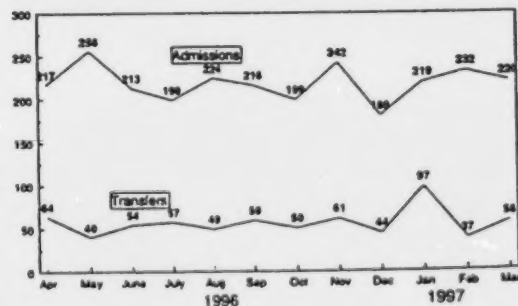


Figure 8
Admissions and Transfers to VPSC by Month for the 1996/97 Fiscal Year

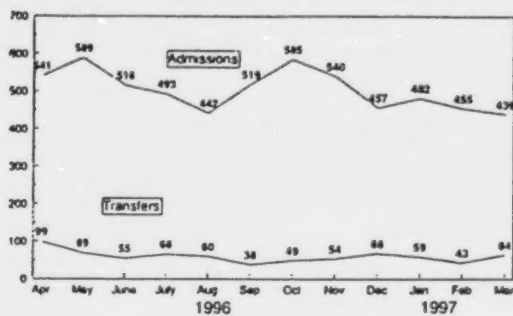
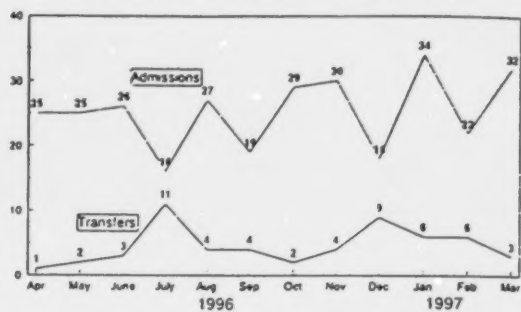


Figure 9
Admissions and Transfers to TCCC by Month for the 1996/97 Fiscal Year



As the information from the above figures show, the number of inmates newly admitted to institutions or transferred into institutions varies considerably across locations. This information will be important below in addressing the proposed plan of mental health services recommended for the Corrections Branch.

Issues Arising from the Review of Mental Health Services in B.C. Jails

The information from the literature reviewed above, and the review I conducted of the mental health services in the Corrections Branch led to the identification of a number of issues that must be resolved. As noted at the outset of this report, the issues fall into two categories: systems issues and service delivery issues. The systems issues must be addressed in order to facilitate the implementation of the mental health plan. By contrast, the service delivery issues will be addressed in the proposed mental health services plan that will follow.

The systems issues include the need to develop: (1) a formal agreement at the provincial level to clarify the responsibilities of agencies with responsibility for mentally ill inmates and to establish minimum standards of care; (2) a Mental Health Services portfolio in the Corrections Branch that parallels the existing Health Services portfolio within the Branch; (3) formal agreements at the local level to ensure that mentally ill offenders' needs are met within the unique context of various institutions and communities around the province; and (4) to establish mechanisms to provide psychiatric care, including the administration of psychiatric medication, to acutely ill mentally disordered offenders in the criminal justice system.

In addition to the systems issues noted above, a number of more specific service delivery issues will be addressed in the development of a mental health plan for the Corrections Branch: (1) screening inmates to identify those with mental health needs; (2) the treatment/intervention of inmates while incarcerated; (3) ongoing or aftercare of mentally ill inmates upon release to the community; (4) screening inmates for risk of self-harm and suicide and providing effective management of them; (5) the need to divert some mentally ill offenders to community-based facilities and programs; (6) the need to develop a mechanism for automating clinical and progress notes to improve communication among mental health care professionals and between health care staff and security staff; and (7) the need to provide additional training concerning the identification and management of mentally ill offenders to corrections officers, health care staff, and mental health professionals working in jails. Although related in scope, the systems issues will be discussed below, and the service delivery issues will be addressed in the proposed mental health plan that follows.

SYSTEMS ISSUES

Four systems issues – those that pertain to the overall organization and structure in which the delivery of mental health services exists – were identified. The first two issues require resolution at the provincial-wide level, and the remaining two must be addressed at the local community level.

Issues to be Resolved at the Provincial Level

ISSUE 1. As it now stands, there is considerable variability among correctional institutions, even those with similar populations and mandates (e.g., pretrial

centres, secure centres), with respect to the nature and extent of the mental health services they provide.

Based on my review, this variability appears to arise from four factors:

- The resources that individual correctional centres have allocated to mental health services (primarily to psychology and psychiatry). For example, some institutions directly contract with psychologists for services.
- Agreements with Forensic Psychiatric Services on an individual institutional basis. For example, there are informal or formal agreements between individual correctional centres and Forensic Psychiatric Services to provide mental health services in the institution.
- Agreements with local agencies apart from Forensic Psychiatric Services that provide services in the correctional centres (e.g., mental health services).
- The lack of minimum standards of care established by the Corrections Branch for identifying and treating inmates with mental illnesses.

This variability in the nature, quality, and level of mental health services delivered in the institutions is unacceptable. It results in considerable animosity and suspicion among correctional staff at the institutions. Of greatest concern, though, is the fact that the quality and level of services available to a mentally ill inmate in British Columbia depends on the particular institution into which he (or she) is incarcerated. At best this is unfair. At worst, it leads to a level of arbitrariness that could raise serious questions about the equitable treatment of offenders with mental illness.

RECOMMENDED SOLUTION 1:

- **A formal agreement must be developed at the provincial level between the government agencies with responsibility for mentally ill offenders (i.e., Corrections Branch, Forensic Psychiatric Services, and Mental Health Services). The agreement is necessary for two purposes:**
 - **to clarify the nature and extent of each agency's responsibility for mentally ill offenders;**
 - **to set in place the minimum standards of care necessary to address the needs of mentally ill offenders when incarcerated in correctional centres and upon discharge to the community.**

The Provincial-wide Agreement. Based on relevant statutes (e.g., Correction Act, RSBC 1996, c. 74; Forensic Psychiatry Act, RSBC 1996, c. 156) and convention, the Corrections Branch, Forensic Psychiatric Services and Mental Health Services have some shared responsibility for the care of mentally ill offenders. While other agencies or departments may also have some related responsibility (e.g., Human Resources, Drug and Alcohol), the primary organizations are the three listed above. A formal agreement – or formal agreements – are required among Corrections, Forensic and Mental Health Services to clarify the role each agency will play in the provision of services to mentally ill inmates. Although such an agreement must be worked out by the affected agencies, upon consideration, the following arrangement, or something like it, might be most appropriate:

- Corrections has overall responsibility for the management, care, and control of inmates, including mentally ill inmates who are incarcerated, or under the purview of community corrections.
- Forensic Psychiatric Services has a responsibility to provide forensic psychiatric services to accused persons who are remanded for psychiatric examination and for persons in need of psychiatric care or assessment while in custody.
- Mental Health Services has an obligation to provide after care community-based services to mentally ill inmates who are released to the community.⁴

Given the above statements concerning the various agency's responsibility for the care of mentally ill inmates, the Corrections Branch must play the central, coordinating, role in ensuring that inmates with mental illnesses are identified and that they receive appropriate services while incarcerated. Forensic Psychiatric Services, through the outpatient clinics around the province, have some responsibility to provide services to mentally ill inmates while they are incarcerated. Furthermore, Forensic Psychiatric Services, through the Forensic Psychiatric Institute, also has a responsibility to provide inpatient services to mentally ill inmates who are certified under the Mental Health Act and who require secure hospitalization that is not available in a psychiatric unit in the community in which the correctional centre is located. Finally, Mental Health Services has an obligation to work with Corrections to ensure that mentally ill inmates have access to the community-based after care that they require. As this paragraph makes clear, the exact nature and extent of responsibility shared by Forensic Psychiatric Services and Mental Health Services must be negotiated and agreed upon.

⁴It should be noted here that during this review, the provincial Mental Health Plan was released. The Mental Health Plan provides considerable optimism for forging the development of community-based services for mentally disordered offenders. However, the extent to which the plan will be realized is uncertain at present. As a result, no specific mention of the Mental Health Plan will be made in this report. It is anticipated that the formal agreements that are developed which include Mental Health Services will explore fully the implications of the Mental Health Plan for the provision of services to mentally disordered offenders.

It is recommended that in developing these agreements, attention be paid to the original "MDO Protocol" developed in 1992, which have generally not been implemented. The MDO Protocols provide much useful information that will be of use to those who ultimately are charged with striking and formalizing new relationships.

The Minimum Standards of Care. In addition to the need for formal agreements about the exact roles and responsibility that each of the agencies must undertake, there is a need to set in place the minimum standards of care necessary to address the needs of mentally ill offenders when incarcerated in correctional centres and upon discharge to the community. While the Corrections Branch must take a lead role in the development of the minimum standards of care, Forensic Psychiatric Services and Mental Health Services should have some input into the standards established since those agencies ultimately will share in the responsibility of providing services to the inmates. Again, with the caveat that the actual minimum standards of care that ultimately are established must be agreed upon by Corrections with input by Forensic Psychiatric Services and Mental Health Services, the minimum standards of care must include the following:

- a systematic program for screening and evaluating inmates to identify those who require treatment
- treatment must entail more than segregation and close supervision of the inmate patients
- treatment requires participation by trained mental health professionals, who must be employed/contracted in sufficient numbers, to identify and treat in an individualized manner those inmates suffering from serious mental disorders
- accurate, complete, and confidential records of the mental health treatment process must be maintained
- information concerning the care and management of mentally ill inmates must be made available to corrections staff on a need-to-know basis
- prescription and administration of psychiatric medications in dangerous amounts, by dangerous methods, or without appropriate supervision and periodic evaluations, is an unacceptable method of treatment
- whenever necessary, psychiatric care must be provided in a psychiatric unit or hospital
- a basic program for the identification, treatment, and supervision of inmates with suicidal tendencies is a necessary component of any mental health program
- attention must be paid to planning for and providing mentally inmates with appropriate aftercare community-based treatment

A Provincial Mentally Disordered Offender Committee. As envisaged by the MDO Protocols, and as currently operates in some form, there should be a "Mentally Disordered Offender Committee" at the provincial level. This Committee should be small, with high level representation from Corrections (i.e., the Provincial Director of Strategic Planning and Corporate Programs), Forensic Psychiatric Services (i.e., the Executive Commissioner – Clinical Services), and Mental Health Services (i.e., the Executive Director or equivalent). In addition, the Director of Mental Health Services in the Corrections Branch (a new position that is recommended below) and Ron Painter, in his present capacity, should serve as members of this Committee. The Committee will be necessary for overseeing both the development of the interagency agreements and the implementation and ongoing monitoring of the mental health services plan that will be initiated. In addition, by having actual input into the planning and implementation of mental health services by high-level personnel in the various agencies, the likelihood that the agencies will become firmly committed to the directions established will be increased.

ISSUE 2. There is a diffusion of responsibility for the development and implementation of mental health services in the Corrections Branch. Furthermore, there is very little centralized guidance provided to mental health professionals in the Branch or to administrators at the institutional or headquarters level. Finally, there is no identified mental health professional in the Corrections Branch who can communicate with other agencies or professionals at a professional level.

Currently, the responsibility for mental health services in the Corrections Branch is shared by a number of people (e.g., Director of Health Services, Provincial Director of Strategic Planning and Corporate Programs, institutional program directors, health care and mental health professionals). This is unsatisfactory for a number of reasons. For example, there is no single person to whom mental health professionals at the institutional level can turn for professional guidance. In addition, there is no mental health professional who can advise corrections administrators – at the local or provincial level – about ongoing mental health issues (e.g., development of relevant policies and procedures, the recruitment of mental health staff/contractors). There also is no single person to take charge and responsibility for the development of a concerted mental health services plan such as that which is envisioned in this report. Currently, there is no mental health professional to represent the needs and to speak for the Corrections Branch with other organizations or agencies. Finally, there is virtually no communication among mental health professionals who work at different correctional centres around the province.

RECOMMENDED SOLUTION 2:

- There is a need for the Corrections Branch to devote resources and attention to developing a Mental Health Services portfolio that parallels the existing Health Services portfolio within the Branch.

The sentiment was expressed by many corrections officers and administrators that the mental health needs and services of inmates is at least as important as the physical health concerns in corrections. Furthermore, the perception among the same people is that the prevalence and needs surrounding mentally ill offenders has increased in recent years. Finally, the mental health service providers, the Director of Health Services, and corrections administrators noted the need for the further development of mental health services in Corrections Branch. To this end, it is recommended that a Mental Health Services portfolio be established. To ensure that the portfolio receive the profile that it requires, it is further recommended that the Mental Health Services portfolio be established in a manner that parallels the existing Health Services Portfolio within the Corrections Branch.

There also appears to be a need to create a position for a Director of Mental Health Services. Ideally, again paralleling the Health Services portfolio, the position would be held by a mental health professional who can provide professional guidance and support to mental health staff and to the Branch generally, and to correctional centres as well. The nature of duties associated with this position will range from assisting program directors at correctional centres with hiring contractors to assisting with system-wide issues. Much of the work of the incumbent in the first two years will be to help address the systems issues discussed here, and to help oversee the further refinement, development, and implementation of the mental health services plan.

Like the Director of Health Services, the Director of Mental Health Services should report to the Provincial Director of Strategic Planning and Corporate Programs. In addition, though, the input into the actual direction of the position, and of mental health services, should be provided by the Provincial Mentally Disordered Offender Committee envisaged above. This will maximize the likelihood of cooperation among the agencies involved and will ensure that the input from the agencies is received directly by the Director of Mental Health Services.

Without knowing which aspects of the recommendations noted here, or of the mental health services plan described below, will be adopted, it is difficult to provide concrete guidance about the length of time the Director of Mental Health Services position will require. Of course, a full-time position would be possible, but might not be necessary or probable given the practical considerations involved. The difficulty is that enough time must be allocated for the Director of Mental Health Services to attend to the priorities outlined at the end of this report, and to provide ongoing support and guidance to mental health professionals and institution-based corrections administrators as well as administrators at headquarters. It is recommended that approximately one or one and one-half days be allocated for this position for a two year period, at which time the position and the length of time allocated should be reviewed.

Issues to be Resolved at the Local (Institutional) Community Level

ISSUE 3. While there is a need for provincial-wide agreements to clarify the responsibilities agencies have for mentally ill inmates and to establish

minimum standards of care, there also exists the need to ensure that the individual and unique needs of each correctional centre are met.

As I toured a number of institutions and talked to the staff there, I could not help but be overwhelmed by the extreme differences among institutions – geographic and otherwise. Quite obviously, the issues and solutions with respect to mental health services that exist in one centre will not be the same as those that exist in other centres. One can hardly imagine the differences between the Vancouver Pretrial Services Centre and a camp like Ford Mountain – not to mention other secure institutions like Kamloops Regional Correctional Centre. As a result, flexibility must be afforded to institutions to implement the minimum standards that are established provincially in a manner and the extent that is appropriate for each institution.

RECOMMENDED SOLUTION 3:

- In addition to the need for formal agreements at the provincial level, there also is a need to negotiate formal agreements at the institutional level between the correctional institution and local agencies with responsibility for mentally ill offenders (i.e., corrections centres, community corrections, community mental health centres, Forensic Psychiatric Services Outpatient Clinics, regional health boards, local hospitals with psychiatric units). Just as with the provincial-wide issues, formal local-level agreements are necessary for two purposes:**
- to clarify the nature and extent of each agency's responsibility for mentally ill offenders;**
- to set in place policies and procedures for detailing how the provincially-established minimum standards will be met at the local level**

Agreements at the local level are necessary because while the general organization of mental health services in corrections and the minimum standards of care must be established at the provincial level, there is a real need to recognize the unique needs, resources, obstacles and opportunities that exist at the local level. In addition, frankly, there are institutions in the province where there does not appear to be a problem with mentally ill offenders (e.g., Nanaimo Correctional Centre, and some of the camps). Finally, many institutions have done a very good job at developing innovative programs to address the needs of mentally ill offenders in their institutions. Thus, a single, uniform, template would not be appropriate for all correctional centres.

Just as at the provincial level, it is beneficial – again as recommended in the 1992 MDO Protocols – to implement local MDO Committees comprised of people who represent agencies that will provide services to mentally ill offenders at the local institutional level. Such committees will be helpful in forging the ties that will be needed to develop and implement services at the local area. In particular, now, there is a need to begin to involve the regional

health boards in planning for services for mentally ill offenders who are being released to the community.

ISSUE 4. Finally, apart from the general concerns that must be addressed to resolve the first three issues identifies above, attention must be paid to the very pressing need of providing psychiatric care, including the administration of psychiatric medication, to acutely ill mentally disordered offenders in the criminal justice system. This issue must be addressed at the local level since the way in which mentally ill people in the criminal justice system may be treated differs considerably from location to location.

One of the most pressing concerns expressed at almost all of the secure centres I visited was the dilemma of how to manage those inmates who are acutely mentally ill. It was reported that it often is impossible to locate a bed in a secure psychiatric unit. As a result, even if inmates are "certified" under the Mental Health Act, the inmates are not provided the treatment required. Most often under these circumstances, the treatment needed is the administration of psychiatric medication, often against the inmate's will.

RECOMMENDED SOLUTION 4:

- Attention must be paid to this problem both at the provincial level and at the local level. Obviously, mechanisms must be developed to provide the much needed psychiatric treatment to inmates on an emergency and ongoing basis. Wherever possible, the inmates must be transferred to a psychiatric unit or hospital. The development of specialized psychiatric units within correctional centres should only be done as a last resort, when all other options fail.

Branch-wide policies must be developed for the administration of psychiatric medication on an emergency and ongoing basis. In particular, protocols must be developed for determining when to invoke emergency powers to administer psychiatric medication to inmates. More importantly, though, solutions must be found to provide ongoing psychiatric treatment to acutely ill mentally disordered offenders. The range of options available are presented below, in order of preference. Again, though, the consideration of these options must be made by the Provincial Mentally Disordered Offender Committee and by local committees with responsibility for overseeing the mental health needs of offenders.

First, for mentally ill offenders who do not pose a security risk beyond that of other involuntary psychiatric patients, and who are charged with minor offences, it is recommended that they are diverted from the criminal justice system to the mental health system. Many of the crimes committed by mentally ill offenders in provincial institutions are minor or nuisance offences and the inmate could be best managed in the long-term by being connected with mental health services in the community as soon as possible. If an inmate who fits the description

provided above is certified under the Mental Health Act, that inmate should be hospitalized in the local psychiatric unit or hospital.

Second, for inmates who are mentally ill, certifiable, and who present some level of risk to others, it is most appropriate that they be hospitalized in secure psychiatric beds in hospitals in the community. At present, many communities in British Columbia do not have secure psychiatric beds in local hospitals. This problem should be rectified if the Mental Health Plan is implemented and secure psychiatric beds are developed in hospitals around the province. Ideally, then, arrangements must be forged between correctional centres and local hospitals to arrange for mechanisms to transfer mentally ill inmates to the secure beds in the local hospitals. On occasion in other jurisdictions, correctional centres have been known to provide 24 hour watch by a corrections officer who is posted to the hospital where the inmate is admitted. While such arrangements do pose difficulties to the complement of corrections officers at the correctional centre, these arrangements may be warranted as an interim measure to getting the inmate to a secure bed in a psychiatric unit or hospital.

It is critical that whenever possible, mentally ill inmates receive care in psychiatric units or the community since the jail is very much a community institution and most mentally ill inmates will be quickly released to the community. Therefore, it is beneficial in the long term to link mentally ill patients to local hospital and community-based resources since they will ultimately need to have access to such services when they are in the community. Finally, of course, there is considerable evidence that many of the offences mentally ill inmates commit are nuisance offences or offences that are otherwise the product of their mental illness. Therefore, by ensuring that they receive the treatment they require in the community, the chances of them surviving in the community and avoiding contact with the criminal justice system are vastly increased.

Third, there is the possibility to develop mental disorder units in correctional centres. In fact, one such unit now exists in the Vancouver Pretrial Services Centre. MDO units may serve two very different purposes. First, inmates who are remanded for forensic psychiatric assessments may be housed there. Second, inmates who require psychiatric treatment may also be housed in these facilities. Most likely, of course, the development of MDO units in jails would serve both purposes. Under the Mental Health Act the advantage of having an MDO unit designated a Provincial mental health facility is that when inmate/patients are certified under the Act, they may be treated against their will. This level of control often is necessary to provide the treatment that acutely mentally ill people require, but so often refuse.

MDO units are most palatable to serve the purposes of providing a forum for assessing inmates who are remanded for forensic psychiatric assessments. However, even then, and under most other circumstances, MDO units are undesirable. Indeed, as Steadman and his colleagues have written:

"Given the importance of caring for disturbed inmates and the frequent inability

of officials to transfer such individuals to state hospitals, the temptation may nevertheless exist to expand the level of mental health care at the jail to a point where all but the most psychotic prisoners can be handled internally" (p. 130).

While this may seem advantageous in the short run, there is a serious danger that any such concentration of services will ultimately reduce the pressure on hospitals and community agencies to provide the much needed and appropriate services to mentally ill offenders.

In addition, as noted above, developing mental disorder units in jails that are not clearly linked to mental health services may simply further separate mentally ill inmates from the very services they will need to rely upon when they are released to the community. Once again, the fact is that most of the mentally ill people in jails will be released to the community within a relatively short period of time. If jails provide mental health services to these people in isolation, without linking these inmates to the mental health service providers or agencies in the community, it will make it all the more difficult for inmates to become reintegrated in the community upon release.

Now that I have dealt with the most pressing systems issues that arose from my review of mental health services in the Corrections Branch, I will turn to the proposed mental health plan and the service delivery issues it entails.

The Proposed Mental Health Plan for the BC Corrections Branch

The Focus of Mental Health Services in the Corrections Branch

At the outset it is important to note that the emphasis of the plan for mental health services that is proposed here is on the six secure custody centres in the province (i.e., FRCC, KRCC, PGRCC, SPSC, VIRCC, and VPSC). Most inmates who enter jails in British Columbia begin at one of these centres. Therefore, if inmates' mental health needs can be identified upon admission to the jail, it is anticipated that a number of subsequent concerns can be diminished (e.g., the occurrence of unexpected manifestations of mental illness, inmates being classified or transferred to other institutions without knowing that they have mental health needs). As a result, the emphasis of the proposed mental health services plan for corrections must necessarily be on the secure facilities.

Reflecting on the information above, two caveats must be kept in mind. First, the Burnaby Correctional Centre for Women, being a unique correctional institution (see Ogloff & Nicholls, 1997), has many different needs for mental health services. Because of the nature of the inmates housed there, and the relationship between the Correctional Service of Canada and the Corrections Branch, the nature and level of mental health services at BCCW should be considered separately. Second, once sentenced, those inmates with mental health needs must be provided with treatment in the facilities in which they are incarcerated (e.g., Ford Mountain). As a result, it is important that these facilities be provided with the level of support necessary to adequately serve the inmates with mental health needs who are incarcerated in them. Without going beyond the scope of this review it is worth noting that correctional centres such as Ford Mountain are necessary. This matter will be discussed following the presentation of the proposed model that follows.

Before presenting the proposed mental health plan, it is important to review the guiding principles and goals that were considered in developing the plan. Those principles will be presented next.

Guiding Principles and Goals for Developing Mental Health Services in Jails

Steadman, McCarty, and Morrissey (1989) developed five planning principles after conducting a national study of 43 jails in 26 of the United States. These principles were considered and expanded upon by Ogloff et al. (1991) in the development of the Surrey Pretrial Services Mental Health Program. With some fine tuning, the philosophy adopted grew out of the interministerial approach adopted by the Committee on the Effects of Multi-Problem Persons on the Criminal Justice System (1991). The principles are sufficiently broad to encompass the concerns that normally occur when considering the concerns and needs of providing mental health services in jails. Therefore, these principles are very useful – even critical – for planning mental health services programs for jails. The principles I have adopted to guide the development of the mental health services plan presented in this report are listed below:

1. Offenders with mental illnesses must be treated with dignity and be provided with mental health services consistent with those enjoyed by other British Columbians.
2. Jail mental health services must be considered a community issue given that jails, in fact, are part of the community, and inmates are from the community and are released back to the community.
3. Jails are and should remain correctional facilities and not specialized mental health institutions. This is not to say that specialized services for mental health assessment and treatment should not be implemented in jails.
4. Jails are primarily correctional facilities, and most inmates will not be in need of mental health services.
5. There is a need for professional services in every jail, and this includes medical as well as mental health professionals.
6. Traditional boundaries that separate government ministries and agencies must be crossed to ensure that mental health services are provided to those offenders in need, and to stop mentally ill offenders from cycling continuously through health, mental health, forensic and criminal justice systems.
7. The core elements of mental health services in corrections include: screening for mental health services (including suicide risk assessment and the identification of dangerous inmates), assessment, treatment, crisis intervention, as well as institutional and post-release community planning and case management.
8. All persons who work with MDO's must play an active role in the identification and management of them (this includes correctional officers, chaplains, and other staff); thus, it is important to provide training to staff to enable them to identify and manage MDO's.
9. While it is necessary to establish minimum standards of mental health care in jails, there is no single blueprint for creating a jail mental health program. Indeed, differences in geography, size of the facility, availability of local resources, and other factors will need to be considered separately for each facility.
10. Program evaluation should be an integral part of the mental health plan and the information generated by the evaluation will be used to determine the extent to which the plan meets its goals and to help identify areas that may benefit from adjustment and further refinement.

Elements of the Mental Health Plan

As noted above, the core elements of mental health services in this report include: screening, assessment, treatment, crisis intervention, as well as institutional and post-release community planning and case management. Figure 10 on the following page depicts the multi stage mental health services program that is recommended. The elements of the program will be reviewed below, following which some particulars of the program will be discussed.

Under some circumstances, inmates may need acute mental health services that are not available in correctional facilities. To determine whether an inmate is so mentally ill that he or she should be transferred to a mental health facility, the mental health professional generally conducts a rather routine psychological evaluation to identify the existence and severity of any psychopathology (Ogloff, Roesch, & Hart, 1993). If the clinician recommends that the inmate be transferred to a secure mental health institution, a transfer should be arranged in consultation with the corrections staff. Where an inmate apparently suffers from a mental disorder that is not serious enough to warrant transfer, the goal of the assessment should be to determine whether the inmate will benefit from a program initiated within the corrections branch.

Given the large number of inmates who enter provincial correctional institutions in British Columbia, and the relatively small percentage of inmates who have serious mental illness and are in need of treatment, it is not necessary or cost effective to perform a complete mental health assessment on every inmate. Thus, the model this program advances uses a two-tier mental health evaluation process. The first step involves a brief mental health screening for every inmate, once upon admission to a provincial corrections centre and then periodically during the inmate's sentence. Second, those inmates identified as mentally ill are referred to mental health professionals for a more complete mental health review.

Most mental health screening in jails is conducted at the time of admission or following a crisis in which an inmate displays acute psychological problems. Such screening may be effective in identifying inmates who require services upon admission to the jail or after suffering an acute episode. However, inmates may develop mental health problems after incarceration (or their problems may intensify) (Hodgins, 1995) but before experiencing a crisis episode, fall between the cracks. Therefore, the mental health programs ultimately adopted by individual institutions must provide mechanisms for monitoring the mental health status of offenders throughout their stay in the institution. Obviously, this will only be of concern for inmates who are incarcerated for some extended period of time (e.g., at least several months).

The model for the mental health plan advocated in this report consists of six separate components: 1) intake screening; 2) ongoing monitoring/screening of inmates; 3) comprehensive psychodiagnostic assessment of MDOs; 4) mental health treatment; 5) gradual/post-release monitoring/supervision and continuity of services; and 6) research evaluation of the program. Each of these components is discussed below.

Intake Screening

Given the relatively high prevalence of MDOs in provincial jails in British Columbia, all inmates should be screened for mental illness soon after admission to a correctional facility. The screening should be brief, with the purpose of identifying inmates who are suffering from mental illness. The model developed for this plan is efficient, cost effective, and applicable to most correctional facilities. The preliminary screening manual is presented in Appendix C.

The screening model recommended is based on that which has been in place at the Surrey Pretrial Services Centre (SPSC) since 1991. The screening model at SPSC has been rigorously tested and found to be effective (Ogloff, 1996; Roesch, 1995; Tien, Ogloff, Roesch, Wilson, Grant, & Mah, 1993). For example, the results in Table 9 make it clear that the screening process is effective. Indeed, only four of the people not identified as mentally ill and referred to the Mental Health Program were diagnosed, using the Structured Clinical Interview for the DSM (a comprehensive interview for the diagnosis of mental illness), as having a major mental illness, namely, Major Depression. Table 9 is a 2 X 2 table that shows the number and percentages of participants who were diagnosed as having a current mental illness based on whether they were, or were not, identified as likely being mentally ill and referred to the Mental Health Program.

Table 9
Current Mental Illnesses by Participation in the Mental Health Program

		Participants in the Mental Health Program?		
		Yes	No	Total
Diagnosed with a Current Mental Illness?	Yes	21 (84%)	4 (16%)	25
	No	34 (33%)	68 (67%)	102
Total		55	72	127

As Table 9 shows, the "True Positive" rate, or the number of people who were referred to the Mental Health Program, and were later diagnosed as having a major mental illness, is 84%. Similarly, the "True Negative" rate, or the number of people who were not part of the Mental Health Program and who were not diagnosed with a mental illness, is high, 67%. Flowing from the Program rationale for screening, that it is appropriate to err on the side of referring people to the Program who may not be mentally ill ("False Positives") rather than failing to refer people to the program who, in fact, are mentally ill ("False Negatives"), there were a significantly greater proportion of false positives than false negatives.

The screening interview recommended, based on the SPSC Mental Health Program, begins with a screening interview of all entering inmates. The SPSC Program uses doctoral students in clinical psychology as interviewers. In many locations in B.C. where there is a secure correctional centre, there would be available graduate students in psychology who could conduct the screening interviews. Where there would not be such people available, experienced psychiatric nurses could likely be trained to conduct the initial screening. Regardless of whether the interviewers are doctoral students in psychology or psychiatric nurses, the interviewers need to be trained and supervised by registered psychologists with experience in corrections.

The interviews are brief (i.e., approx. 20 minutes), but provide sufficient information to make initial decisions about the mental health needs of incoming inmates. As indicated in Appendix E, the screening procedure includes a brief semi-structured mental status interview and the Brief Psychiatric Rating Scale (Overall & Gorham, 1962). The interview covers seven content areas: Personal/demographic information, suicide risk, orientation to time and space, criminal history, recent social adjustment, recent mental status, and mental health history.

The screening should normally be completed within the first day of admission to jail. The purpose of this screening is to detect serious mental disorder requiring rapid management, treatment, or further evaluation. It is desirable to minimize false negative errors at this screening stage (inmates who have a mental disorder that is not detected). It will allow those inmates who do have a mental illness to be evaluated further.

Intake screening should address immediate mental health needs of incoming inmates. Assessment for long-term intervention is inadvisable because a more comprehensive assessment can take place at a later time if indicated and the need is warranted. Inmates who may be good candidates for long-term intervention can be flagged at the initial screening stage and then monitored until there is an opportunity for treatment assessment.

The screening services should be provided in all facilities that have a sizeable intake of new admissions (see Figures 2-9): BCCW, FRCC, KRCC, PGRCC, SPSC, VIRCC, VPSC and, possibly, TCCC.

Supplementing the screening model in the SPSC Mental Health Program, it is recommended that three additional measures be made available for use by screening interviews where indicated. While the basis mental health screening should be performed on all incoming inmates, there is a need to provide a more extensive screening under some circumstances. In particular, when interviewers identify inmates who may be at risk of self-harm or suicide, harm to others, or exhibiting signs of intellectual impairment, it is recommended that an additional measure be completed to provide further information to assist with classification and intervention decisions. When indicated, then, the screeners could administer one or more of the following measures: the Estimate of Suicide Risk, the "H" (Historical) scale of the HCR-20 (risk of harm to others), or the Test of Nonverbal Intelligence (to identify inmates with significant intellectual impairment which may result in functional difficulties).

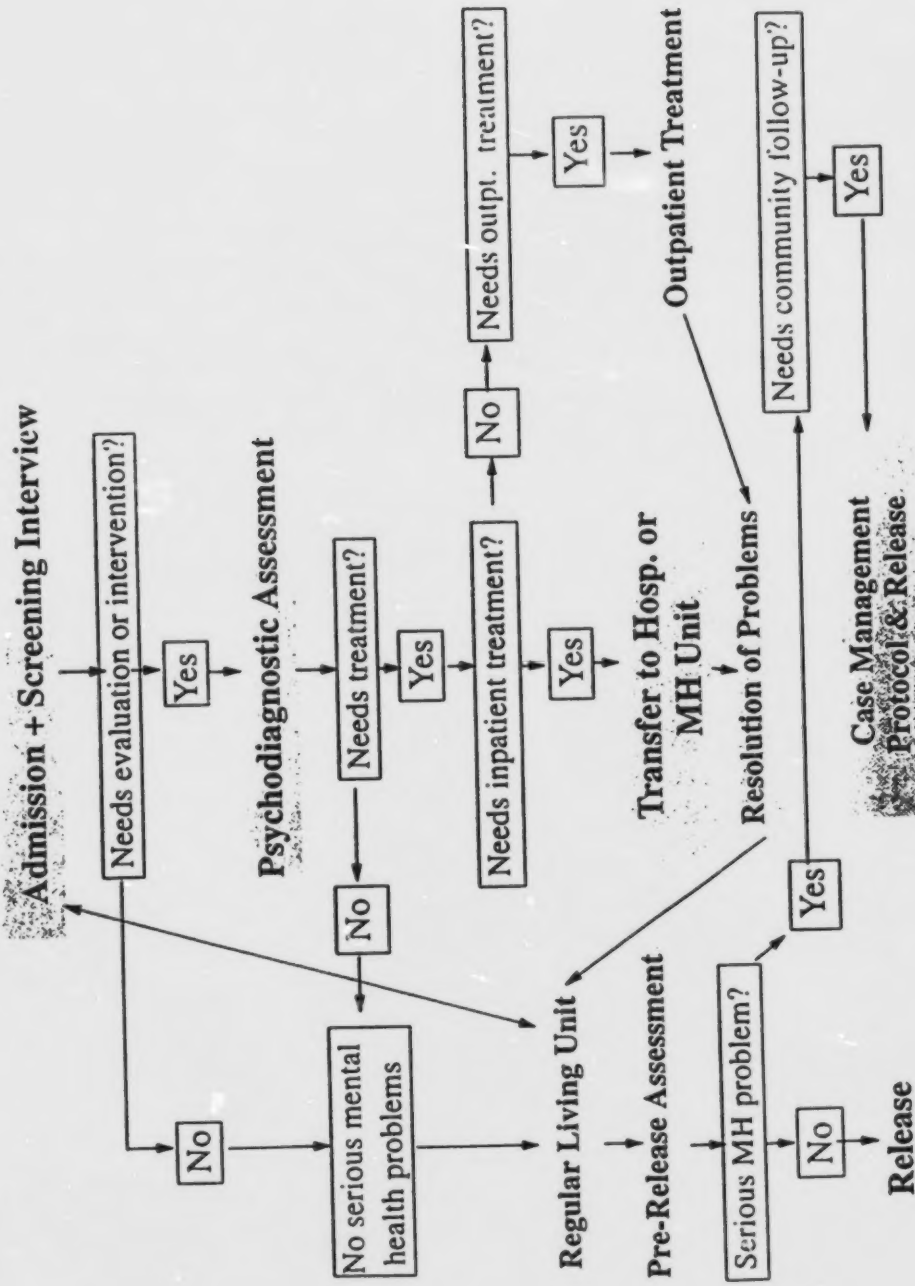
Ongoing Monitoring/Screening of Inmates

The model places heavy emphasis on prevention and early intervention. Therefore, an essential component is a formal process for ensuring that inmates are monitored, both formally and informally. The system also should encourage self referrals to facilitate access to treatment services. In addition to formal assessment, those correctional officers who are in frequent contact with inmates should be trained to recognize signs of mental disorder (Kropp & Cox, 1989). Correctional officers should be in a position to detect early signs of mental health problems and to refer these problems to mental health professionals. Because training correctional officers to detect symptoms of mental disorder is inexpensive ongoing screening and evaluation is feasible in all jails (Dvoskin & Steadman, 1989). However, once officials detect mental illness, mental health professionals must be available for further assessment and treatment.

In addition to corrections officers, other staff, particularly chaplains, teachers, and others should be drawn upon to assist with monitoring inmates who have been identified with mental health problems. Moreover, they also should help with the identification of inmates who have not yet been identified as being mentally ill, but who may develop problems during incarceration.

Figure 10

Multi Stage Mental Health Services Program for MIOs



Comprehensive Psychodiagnostic Assessment of MDOs

In many cases, of course, an inmate's stay in jail may be too brief for any further assessment. The purpose of more comprehensive assessment, where possible, though, is to determine mental status and treatment needs of inmates who are flagged as potentially mentally ill during the initial screening or subsequent monitoring process. Again, the emphasis of all mental health assessments is to obtain the information needed to make decisions about appropriate classification and treatment services. In larger correctional facilities, mental health professionals are employed or contracted and are located in the institution; however, in small jails, or sentenced facilities with a small number of mentally ill inmates, it is often more feasible to have mental health professionals from nearby community mental health centers attend at the jail on an "as need" basis (Ogloff & Roesch, 1992). Through such an arrangement, a community mental health center (or equivalent) could provide assessment and treatment services while the inmate is incarcerated and services following release if the inmate remains in the local community.

In addition to "routine" comprehensive reviews of inmates identified as possibly mentally ill and referred to mental health professionals, on occasion there will be a need to give a comprehensive psychodiagnostic examination to inmates to determine whether they are acutely mentally ill and whether they should receive treatment in the institution or be transferred to an inpatient treatment facility. In some instances, of course, inmates will be identified as seriously mentally ill, in need of psychiatric treatment, and at risk of harm to themselves or others. In such cases, the inmates can be "certified" and transferred to hospital. As noted earlier in this report, there is a real need to have access to secure psychiatric hospital beds in the community.

Where indicated, the diagnostic examination also determines what mental illness an inmate has and provides a more functional assessment of an inmate's specific problems. For example, a diagnosis of schizophrenia, by itself, gives little direction to treatment providers or corrections staff. However, knowledge that an inmate experiences delusions or has difficulty controlling aggressive impulses allows treatment officials to engage in specific interventions designed to ameliorate these problems. It also provides important information to corrections staff about the inmate's classification and management needs. Therefore, the assessment of inmates referred from intake or ongoing screening should include an assessment of the inmate's specific behavioural problems.

Mental Health Treatment

Once an inmate is assessed with a mental illness that requires treatment, he or she should be referred to an appropriate treatment program within the correctional facility or Branch if possible and practical (e.g., a sentence lengthy enough to warrant treatment or intervention). If the inmate has a serious mental illness, and there is no existing treatment program available, the inmate should be transferred to an appropriate facility. Again, if an inmate requires treatment but is not certifiable, it may be possible to have mental health intervention provided by staff from local

community mental health centres.

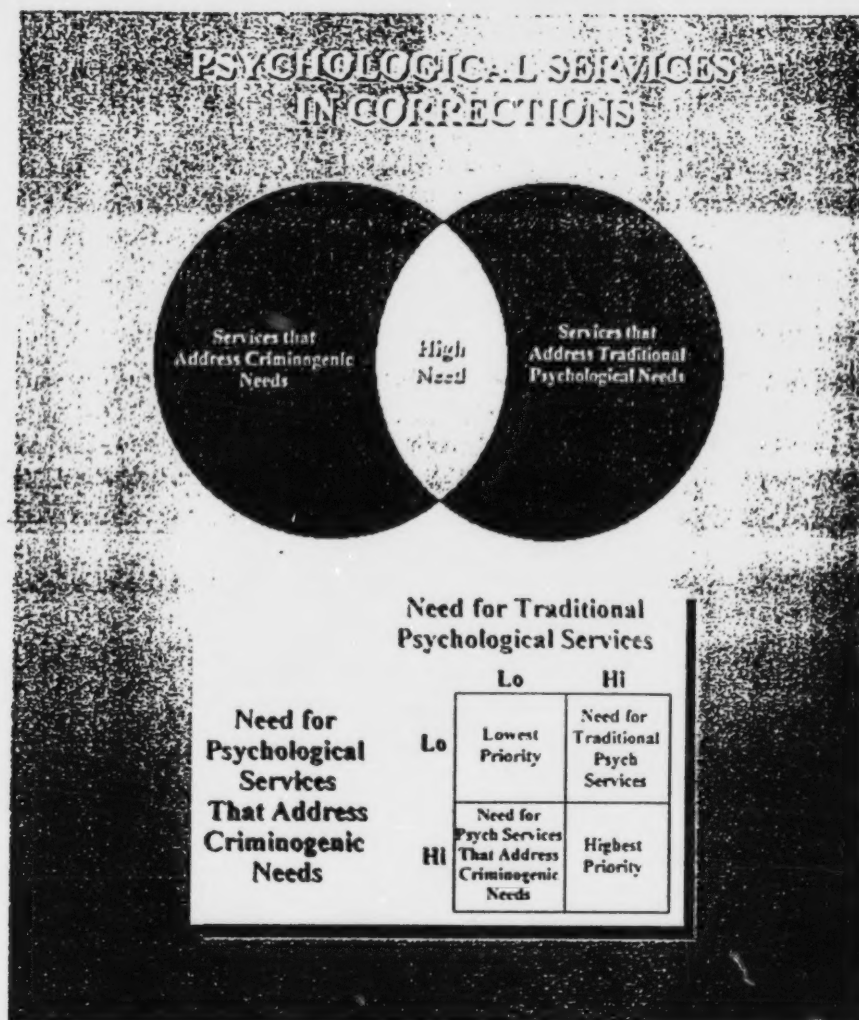
The size of the jail and its mandate (e.g., sentenced facility versus pretrial facility) affects the type of service available. While there are a number of treatment programs designed specifically for jail inmates, the reality is that most jails currently provide little treatment. The Corrections Branch is developing "core programs" that will touch on some issues related to mental health needs (e.g., substance abuse). These programs likely will be more educative than therapeutic in nature. The most common form of treatment in jails for mentally ill offenders is psychotropic drug therapy (Gudjonsson, 1990; Bloom & Bradford, 1988). Various forms of behaviour therapy, particularly cognitive behaviour therapy, are among the more popular types of psychotherapy (Gudjonsson, 1990). Some correctional centres in British Columbia have developed specific treatment programs for subgroups of inmates, such as sex offenders or offenders with anger management problems.

It is important to note that, as Figure 11 shows, the two types of psychological needs (or services) that exist in correctional facilities – traditional mental health needs/services and services that address criminogenic needs – are related. Indeed, there is considerable overlap between these two types of needs/services. Thus, it is very often difficult to separate, on an individual basis, an inmate's traditional mental health needs from those that relate to his or her criminogenic risk factors. As the research literature, including previous research in British Columbia, incarcerated offenders have a markedly higher level of psychological illnesses and issues than is found in the general population.

As the table in Figure 11 depicts, though, some degree of differentiation is required based upon the level of traditional or criminogenic need for any given offender. Clearly, those offenders who demonstrate a high need for both traditional psychological treatment and intervention for their criminogenic needs should be the highest priority for treatment. By contrast, those inmates with a low need for intervention in both domains are the lowest priority for treatment. Treatment should be provided to inmates who variously demonstrate a high need for either traditional intervention or for intervention to reduce their criminogenic risk factors. The priority between these two domains depends largely on the extent to which the psychological needs are "essential." Essential needs would be given a higher priority than non-essential services that are geared toward facilitating the inmate's rehabilitation and successful reintegration into the community.

Consideration of the information presented in Figure 11 and discussed here is important when considering the actual need for developing MDO treatment programs and, further, in helping to decide which inmates should be prioritized for such treatment. There always exists the concern in corrections that many, perhaps even most, offenders could benefit from some sort of mental health intervention. Almost by definition, inmates have sometimes significant problems in living. However, as Figure 11 shows, the priority for mental health treatment – given the fiscal and practical limitations in the Corrections Branch – requires that consideration for mental health treatment be given to those inmates who are at highest need for intervention.

Figure 11



Gradual Post-Release Monitoring/Supervision and Continuity of Services

Treatment that begins in jail should continue post-release into the community (Ogloff & Roesch, 1992; Ogloff & Tien, 1991). Many treatment programs initiated in jails terminate once the inmate is released. The transition back to the community is often difficult, as evidenced by high recidivism rates. It is essential that the assessment and intervention process that begins in jail continue after release, in cases where this is deemed appropriate. Again, the voluntary nature of participation in treatment should be recognized, but if the inmate is interested in continuing treatment post-release, efforts should be made to facilitate this.

Unfortunately, continuity of treatment, on a post-release basis, is rare. In those jail/community programs that are effective in assimilating MDO's back into society one consistent factor seems to be associated with their success: the existence of a core person responsible for managing the interactions of mental health, jail, and judicial personnel (Steadman, 1989). Also known as a 'boundary spanners' this individual has responsibilities that reach into all areas of the rehabilitation process, to ensure that jail and community services programs provided the needed services. Regardless of this core person's title or professional qualifications, it is essential that such individuals have the responsibility of ensuring that the two systems interact effectively and efficiently.

This model can be applied to the integration of mental health services in jails and community services, making continuity of treatment more likely. The only problem with implementing such a program is the fact that inmates are released into communities on a province-wide (or even out-of-province basis). Thus, many boundary spanners would be needed to apply this model to the correctional system. As noted in the "systems issues" section discussed previously, efforts must be made at both the provincial and local levels to coordinate services between corrections and other agencies, including those in the community. Such relationships are important to develop linkages with service agencies that can help an inmate with mental illness obtain services in the community – services that will help decrease the likelihood that the offender will reoffend and return to the correctional system.

Program Evaluation

The evaluation component of this mental health plan is just as important as the other components in achieving assessment and delivery of mental health services. For example, the screening package presented in Appendix E, along with the additional measures to be used when needed, must be empirically tested and evaluated.

Also, wherever possible, assessment must be linked with treatment. Mental health professionals conducting the evaluations can make recommendations for treatment based on their assessment of an individual's needs. These recommendations are based on perceived need and on the availability of services. Often the most appropriate treatment will not be available or the inmate will not be incarcerated long enough to take advantage of treatment programs. Compromises often must be made. It is all the more important, then, that ongoing evaluations of the effectiveness of the assessment/treatment decisions be built into the system. Evaluation informs decision-makers about the outcome of their decisions. Over time, this feedback can lead to improvements in the assessment, referral, and treatment phases of the model. Data on the base rates of mental disorder – and the number of inmates who fall into the MDO categories – also can prove valuable in planning for future treatment needs.

Staffing Needs for the Proposed Mental Health Services Plan⁵

Given the recommended focus – at least initially – on developing a multi-stage mental health services program for the secure custody institutions, attention must be paid to the staffing needs required for the plan. Like any other program, the ultimate success of the mental health plan to be implemented in each secure custody facility ultimately will depend upon the staff who perform the day-to-day duties required by the program. To satisfy the principles set out in this report, staff positions have been considered carefully to ensure that the most effective allocation of resources would be made given the limited staffing resources available. The mental health staff or “team” is necessarily interdisciplinary and should include a nurse, social worker/community liaison worker, psychologist, psychiatrist, intake interviewers, and administrative/clerical staff. The role of each category of staff is described below. Figure 12 depicts the recommended organization and functional relationship of mental health services for the secure custody institutions in the province.

Figure 12
Recommended Organization of
Mental Health Services in Corrections



⁵Staffing needs and costs associated with the mental health staffing needs at the BCCW are not included here. In addition to the staffing needs of the secure custody facilities, there will be additional staffing costs associated with facilities that provide treatment to MDOs.

To implement the mental health plan described in this report and to satisfy the principles and goals presented, it is important that a mental health team be established at each of the secure custody centres. The amount and nature of staff requirements will vary by institution. For example, while the large number of admissions to the SPSC and the VPSC, and the prevalence of mental illness among inmates in those facilities, would warrant a full-time psychiatric nurse, facilities like FRCC, KRCC, and PGRCC may not justify a full-time position. Nonetheless, the positions described below are those required to form the basis of the mental health services plan, regardless of the length of time each person works in the jail on a weekly basis. Also, it may be possible in some facilities to combine two positions (e.g., the community liaison worker could serve as the coordinator and the services of a psychiatric nurse could be limited or even eliminated depending on the other nursing staff available. It should be noted, too, as will be discussed below, that many of the positions noted in Figure 12 are not directly part of the mental health "team;" rather, they provide input into the mental health program by liaising with mental health staff, making referrals for services, and the like.

The Mental Health Team

Nurse Coordinator. The principal functions of the Nurse Coordinator are to coordinate the functional activities of the mental health professional staff, and to participate in the assessment, treatment and institutional and community case management planning for mentally disordered inmates in the jail. The Nurse Coordinator will be the first person to see inmates following the screening referral made by the intake interviewers in order to determine the level of services the inmate may require and which other member of the team the inmate should see.

Community Liaison/Social Worker. The establishment of the link between the jail and mental health services in the community is one of the most important features of the plan. To date, there has been little systematic efforts to integrate mentally ill inmates back into the community and to link them to community resources. Most community mental health centers, for example, are not involved at all with local jails, despite the reality that most inmates return to the community within a short period. The principle responsibilities of the community worker are to participate in assessments as a member of the multi-disciplinary team, as well as to develop, coordinate, and implement post-release care plans for inmates identified as mentally disordered. The community workers will also be responsible for obtaining information about previous mental health services the inmates may have received in order to attempt to arrange continuity of treatment for the inmates.

Psychiatrist. The psychiatrist provides psychiatric assessment and treatment for inmates receiving care during their stay in the jail. To provide emergency psychiatric evaluation and treatment during periods when on site mental health care resources are unavailable, jails must make use of on-call psychiatric staff. Under the provisions of the provincial mental health act, the psychiatrists also have the authority to certify inmates and to have them involuntarily committed to a mental hospital when necessary. Finally, psychiatrists who have admitting

privileges in local hospitals with psychiatric units may be more effective at obtaining care in the hospital for the inmate than other personnel who do not have such privileges.

Psychologists. Psychologists provide psychological assessment and treatment to inmates referred to the mental health team. They will conduct the psychodiagnostic evaluations presented in the model depicted in Figure 10. They should play a major role in the institutional and community case management plan for inmates referred to the team. Psychologists also will assist with critical incidents and crisis intervention. In addition, psychologists also can provide on-site supervision to intake interviewers.

Intake Interviewers. Intake interviewers, who are ideally doctoral students in clinical psychology, conduct intake interviews and gather systematic intake information relating to mental health on all inmates admitted to the facilities. The intake interviewers refer to the team those inmates who are mentally ill and/or those inmates who are at risk for self-harm and who require mental health services. Intake interviewers also liaise closely with sentence management and classification staff to ensure that inmates with special needs or risks have those needs met or risks managed in the institution.

Clerical/Administrative Staff. Clerical services and administration of the team should be provided by corrections personnel. Most typically, the Director of Programs will have ultimate responsibility at the institutional level for the mental health team.

The alcohol and drug counsellor (or equivalent) should also be affiliated with the mental health team, given the extensive overlap between offenders with mental illness and substance abuse problems. In addition, other staff members at the institutions (e.g., correctional officers, nurses) should participate in the identification and management of mentally disordered inmates. Accordingly, training must be provided to line staff regarding the identification and management of mentally disordered offenders.

Projected Costs Associated with the Mental Health Teams

Ideally, staffing responsibilities and costs will be shared among Corrections, Forensic Psychiatric Services, and Mental Health Services. For example, it is my understanding that Forensic has received additional FTE positions this fiscal year, some of which it plans to dedicate to secure custody institutions in Corrections to work as court and community liaison workers. This sort of arrangement is highly recommended, as long as arrangements can be made at the provincial level to ensure that – wherever possible – resources are allocated on a comparable basis to all correctional institutions with similar needs. It is very difficult to estimate the actual staffing needs and costs associated with implementing the mental health plan proposed in this report. Ultimately, the Provincial MDO Committee and the Director of Mental Health Services will have to allocate resources to correctional facilities. Based on a preliminary review, though, the following staffing estimates are provided on a per institution basis:

KRCC, PGRCC, VIRCC

- 1 psychiatry session; plus on-call coverage (covered by MSP where possible)
- 6 psychology sessions per week (\$80,000 annually)
- 1 day of psychiatric nursing time (\$20,000 annually)
- Intake interviewer time (\$30,000 annually)
- 1 FTE community liaison worker (provided by Forensic Psychiatric Services)

Total annual estimated combined costs for these facilities: \$350,000

Notes: At KRCC psychiatric nurses likely will be required to do the mental health screening. Therefore, at that centre the intake interviewer time will be eliminated and the psychiatric nursing time will be increased. At PGRCC and VIRCC some psychiatric nursing services currently are provided by the Forensic Psychiatric Services Outpatient Clinics; therefore, it is possible that the costs to Correction will be less than the amount estimated above.

FRCC, SPSC, VPSC

- 2 psychiatry sessions; plus on-call coverage (covered by MSP where possible)
- 10-12 psychology sessions (\$135,000 annually)
- 0.5 FTE psychiatric nursing time (\$30,000 annually)
- \$55,000 intake interviewer time (\$24,000 at FRCC)
- 1 FTE community liaison worker (provided by Forensic Psychiatric Services)

Total annual estimated combined costs for these facilities: \$464,000

Notes: At SPSC the psychology sessions and psychiatric nursing staff position are provided by Forensic Psychiatric Services.

As the above estimates show, the total costs for the mental health services at the six centres noted above is \$814,000. This exceeds the amount spent for psychological services in the 1997/98 Fiscal Year (2618 sessions = \$672,839); however, the additional costs are required for psychiatric nursing time and intake interviewer time. If this plan is adopted in some form, further planning could lead to cost containment and possible reductions. Once again, though, such matters would require consultation at both the provincial and institutional level.

It should be emphasized that the above budget is tentative. For example, after implementing the plan for one year, clear information would be available concerning the actual number of inmates who require mental health services in each jail. In addition, an argument could be made for obtaining funding from Mental Health Services from the new Mental Health Plan for some of the costs associated with providing psychological and nursing care of mentally ill inmates while they are incarcerated. In addition, the costs are estimates based on the total number of admissions to the institutions. If, as anticipated later in this report, salient information from the intake screening is maintained for each inmate admitted, most of those inmates who are admitted

repeatedly in any given year will not need to be "re-screened." As a result, there will be a reduction in the estimated intake screening budget. Finally, it is possible that additional support, particularly by part-time psychiatric nurses will be provided by the Forensic Psychiatric Services Outpatient Clinics in the province. Again, cost savings will be realized there.

Suicide and Self-Harm Identification and Management

Suicide and self-harm are one of the most severe threats to inmates' safety in correctional facilities, and, in turn, has a traumatic effect on other inmates and correctional staff (Ramsay & Tanney, 1987). Therefore, any mental health jail program must attempt to identify those inmates who are at a risk for suicide. Unfortunately, due to the low base-rate of suicides in prisons, it is difficult to identify inmates who likely will attempt to take their own lives (Hayes, 1983). In Appendix C to this report, Ms. Lindsey Jack has prepared a comprehensive, yet concise, review of the risk factors and assessment issues related to suicide and self-harm in jails. In this section, I will provide some general information about the incidence of suicide and self-harm in the institutions in the Corrections Branch, and make recommendations regarding the identification and management of inmates at risk for self-harm.

Table 11 represents the number of incidents of self-harm and suicide in adult corrections in British Columbia for the past three fiscal years. The rate of suicide for the general population in British Columbia also is presented for comparison purposes.

Table 11
Incidents of Self-Harm and Suicide in Adult Corrections

	BC Jails			BC General Population
	Self-Harm	Suicides (Number)	Suicide Rate/100,000	Suicide Rate/100,000
1994/95	101	3	15	10
1995/96	99	2	10	11
1996/97	165	1	4	9.7
Means	122	2	10	10

As the table above shows, the suicide rate in British Columbia's jails closely approximates that of the general population. This is positive since, as discussed in Appendix C, the suicide rate in most jails in North America is two or three times that of the general population. In addition to the low number of suicides, relatively few incidents of self-harm by inmates are reported annually.

The information presented in Appendix C explains that suicide cannot be predicted with any

appreciable degree of certainty. This is because of the very low base-rate of suicide in society and in jails. Considerable research has been conducted in jails and prisons to identify the factors that relate to the risk that inmates may harm or kill themselves. These factors are explained in Appendix C. Because it is impossible to definitively predict who will kill themselves, the best we typically can do is identify those inmates who display factors that we know have been found to relate to a risk of self-harm or suicide. Some scales or measures have been constructed that enable one to review the factors that relate to a risk for suicide or self-harm in an individual inmate's case. One such measure that shows considerable promise is the Estimate of Suicide Risk (ESR; Polvi, 1996). The ESR is presented in Appendix D. It consists of items that have specifically been found to relate for a risk of self-harm and suicide among inmates. The ESR is very useful since the interviewer or mental health professional can identify whether and to what extent an inmate displays factors that relate to risk of self-harm or suicide.

Because of the difficulty predicting suicide, it is problematic to rely on any score derived from a scale. Instead, people who come into contact with inmates need to learn to identify the factors that relate to a risk of self-harm or suicide. In addition, it is useful for them to understand the relative importance of some of the factors for the inmate. However, an inmate may display few of the factors that are predictive of suicide risk, yet because of the inmate's situation, the staff member knows that the particular factor that the inmate displays may place him at an increased level of risk. For example, an inmate who learns while incarcerated that his wife is separating from him may be at risk for suicide, depending upon other factors in the inmate's life. What this all means is that, rather than relying on some final score on an instrument, staff must be familiar both with the individual inmate's situation, and the suicide risk factors the inmate demonstrates.

As a result of the low base-rate of suicide in jails, even the most conservative suicide screen will over-represent people who are identified as being at risk. Given the serious nature of self-harm or suicide, though, it is desirable to err on the side of caution. Therefore, as is currently the case, care must be taken to classify and house inmates who are identified as being at risk for self-harm or suicide in observation in the jail to ensure that their level or risk is managed. The development of a uniform suicide/self-harm policy is useful to provide some guidelines for identifying whether an inmate is at risk, and when that risk diminishes.

Finally, it would be very beneficial for the Corrections Branch to systematically collect data from the ESR on all inmates who are admitted to jail for a period of approximately three months to enable an evaluation of the validity of factors on the ESR to ensure that they are useful for the population of offenders in British Columbia.

Additional Considerations to be Addressed in the Mental Health Plan

Clinical Notes, Information Sharing, and Providing for Continuity of Information

The review revealed considerable concerns from mental health professionals and

correctional staff alike about clinical notes, information sharing, and providing for continuity of information. Once again, this is an area that will require the attention of the Provincial MDO Committee and the Director of Mental Health Services to develop actual standards and protocols. It must be noted, though, that my review revealed in this context and others that very often staff are not aware of existing policies and directives. For example, there is a directive (ADM Directive 95:03) and other documentation on information sharing between treatment professionals and corrections staff about which some staff had no apparent knowledge.

There are two files of interest here: the progress file and the healthcare file. Corrections staff do not have access to the healthcare file, but they do have access to the progress file. Professional ethics, provincial legislation, and case law establish the need for limited confidentiality between mental health professionals and inmates receiving mental health care (see Ogloff, 1995). Nonetheless, exceptions to the limited confidentiality provisions are required to provide information to corrections officers that is relevant to an inmate's management. Therefore, while mental health professionals must log clinical notes in the healthcare files, information that is relevant to the management of an inmate must be logged in the progress file on a need-to-know basis. Corrections officers were careful to emphasize that while they did not expect – or wish – to learn about sensitive diagnostic or personal details about inmates, they have a very real need to have access to information from mental health professions that can assist them with classification, management, and support of inmates with mental illnesses.

Great concern was expressed about the lack of continuity of information about MDOs who are transferred between or among correctional institutions. For example, while all inmates are screened for mental illness at SPSC and many are screened at VPSC, this information typically is not shared when an inmate is transferred to another institution. In particular, information alerting correctional staff to the possibility that an inmate has a mental illness does not follow the inmate. This leads to problems from repeating screening assessments in close temporal proximity (even within an institution like SPSC) and in transferring a mentally ill inmate to another institution without alerting staff there of the inmate's mental status.

One possible solution to help correct this problem is to create a mental health field on the computer system (either or both the Provincial Case File System or the Correction Administration Records Entry (CARE) system). Once an inmate was screened upon admission to a correctional centre, that fact would be indicated on the system. If the inmate was identified as being in need of mental health services a "mental health alert" could be recorded. This would alert corrections staff that the inmate may have mental health problems. Additional codes could be developed to provide further information on line. Alternatively, corrections staff could access the progress log where any information of importance to corrections staff regarding the inmate's needs or management concerns would have been recorded.

The on-line information also would be of use to help intake interviewers – and other mental health care staff – decide whether an inmate who is "newly" admitted or who is transferred in requires a very cursory or more extensive screen.

Diversion of Mentally Ill Offenders

As discussed in this report, to address the concerns of mentally ill offenders, steps have been taken in British Columbia to screen inmates entering the pretrial facilities (SPSC and VPSC) for mental illnesses and to provide mental health services as needed (Ogloff et al., 1991). However, as research in the SPSC shows, many of the mentally ill offenders have not committed violent crimes. Indeed, during a one-year follow-up of inmates released from the SPSC, those who were mentally ill were significantly less likely to reoffend by committing an offence against a person (12.5%) when compared to inmates who were not mentally ill (36.7%). Further, many of the inmates with mental illnesses did commit new offences during the follow-up, but most of the offences were minor in nature, and many may be the result of the lack of services available to the offenders while they were residing in the community. Indeed, almost 75% of inmates made contact with the Ministry of Social Services (now called Human Resources) to receive benefits following their release from the SPSC.

While the mental health services for offenders who are detained in jails and prisons in British Columbia may be adequate under most circumstances, **the same cannot be said once the offenders are released to the community.** Indeed, many offenders do not receive adequate mental health care, which, in turn, may lead them back to the criminal justice system.

Given the prevalence of mental illness among offenders, the non-violent and minor nature of many MDOs' offences, and the lack of appropriate community treatment and residential facilities for MDOs, it is not surprising that many cycle back and forth between the mental health and criminal justice systems. What is needed is an **alternative** for apprehending and releasing MDOs to the community without appropriate treatment.

It is recommended that systematic attention must be paid to developing programs to "divert" dually diagnosed mentally ill offenders out of the criminal justice system, either at some point before arrest, or following arrest once they have been screened for mental illness and risk.

The Need for Treatment Programs/Facilities for Incarcerated MDOs

As stated at the outset of this section, in addition to the basic mental health services plan presented, based on the number of offenders with mental illness in correctional institutions in British Columbia, there is a need to ensure that treatment programs and/or facilities are available to treat MDOs while they are incarcerated. Currently, a number of institutions in the Branch do offer such services (e.g., Ford Mountain). There is a need for the Provincial MDO Committee to consider expanding such treatment programs to accommodate the needs of offenders who are mentally ill, but who are not so acutely mentally ill that they require certification and treatment in a secure hospital unit.

During the course of the review, a number of people with whom I met discussed the possibility of incorporating a treatment program for MDOs in a correctional centre such as New

Haven Correctional Centre which is located centrally in the lower mainland. Such options have considerable merit and need to be considered.

It should be emphasized that given the limited resources available, it is important NOT to expect every sentenced facility to provide mental health treatment to MDOs. Rather, it makes sense to transfer MDOs to facilities which have specialized programs to accommodate their needs. For example, on Vancouver Island, inmates with mental illness admitted to NCC typically are transferred to VIRCC.

The Role of Corrections Officers and Other Staff in the Identification of and Management of MDOs

Given the sheer number of inmates who flow through the jails annually, it is impossible and impractical to expect that the few mental health professionals and support staff available will suffice to identify and manage all of the offenders with mental illness in the jails. Concerted efforts must be made, then, to involve line staff – particularly corrections officers – in the identification and management of mentally ill offenders. Indeed, a large number of corrections officers have undergraduate degrees in social sciences, including psychology and criminology. One of the goals of the Director of Mental Health Services and Corrections Administration should be to attempt to increase the involvement of corrections officers in the identification and management of mentally ill offenders.

At the VIRCC, a "special handling unit" has been developed that houses inmates with mental illnesses among others. The unit is double-staffed by corrections officers who closely monitor the conduct of the inmates. The officers are very involved in the ongoing progress and outcome of the inmates. This sort of model is useful for seeing how the role of corrections officers can expand to facilitate the services provided to mentally ill offenders.

Most of the corrections staff with whom I spoke mentioned the need for continued training in the identification and management of MDOs. I was able to review the material provided in courses at the Justice Institute regarding MDOs. That material appeared very useful, and that message was relayed by corrections officers who had received that training. Of concern to many officers, though, was that if they worked closely with MDOs (e.g., in the Special Handling Unit at VIRCC or in the MDO Unit at VPSC), the training seemed to lack depth and was too abstract for their needs. By contrast, those officers who do not come into close and frequent contact with MDOs felt that the training was "overkill." As a result of these sentiments, there does appear to be a need to provide further training to staff who work with MDOs either in more advanced programs at the Justice Institute or in in-house training that can be tailored to the specific needs and situation in the particular institution in which the officers work. The latter option is likely better but, again, would require resources for training.

Apart from corrections officers, training is required for other staff (i.e., health nurses, chaplains, teachers, and mental health professionals who are new to corrections or new to the

provincial system in British Columbia). Again, this training can be coordinated through the Justice Institute or it can be delivered at the particular institutions where it would be directed toward the needs of the institution.

Conclusion: Priorities and Time Line

Given the extensive amount of information covered in this report, it would be impossible to implement all of the suggestions made immediately – even if funds and human resources were available. It is necessary, therefore, to establish recommended priorities for implementing the suggestions made in this report. With careful planning and initiative, the mental health plan could and should be fully implemented within a two year period. There, of course, still would be further fine-tuning and refinement required on an ongoing basis. The specific recommendations listed below follow logically for the most part. Of course, given that some aspects of the mental health plan are in place now in institutions and other plans are underway in the Corrections Branch, it is possible that some of the recommendations will have to be altered.

- Recommendation 1: (Re-)Establish the Provincial Mentally Disordered Offender Committee.
- Recommendation 2: Establish a Mental Health Services portfolio within the Corrections Branch that would parallel the Health Services portfolio; this would include the appointment of a Director of Mental Health Services.
- Recommendation 3: Wherever possible within secure custody institutions establish a mental health team on a *pro tem* basis to begin to facilitate the mental health plan at the centre.
- Recommendation 4: Negotiate a provincial-wide agreement between the Corrections Branch, Forensic Psychiatric Services, and Mental Health Services to: (1) clarify the nature and extent of each agency's responsibility for mentally ill offenders and (2) to set in place the minimum standards of care necessary to address the needs of mentally ill offenders when incarcerated in correctional centres and upon discharge to the community.
- Recommendation 5: Work with provincial agencies and ministries and local psychiatric units and provincial mental health facilities to make arrangements for the transfer and provision of care for acutely mentally ill offenders who are certifiable under the Mental Health Act and who require psychiatric treatment.
- Recommendation 6: Establish Mental Disorder Committees at the local institutional/regional level to: (1) clarify the nature and extent of each agency's responsibility for mentally ill offenders and (2) to set in place policies and procedures for detailing how the provincially-established minimum standards will be met at the local level.
- Recommendation 7: Establish a mental health team and implement the mental health plan components at each of the secure institutions (with the following

components: 1) intake screening; 2) ongoing monitoring/screening of inmates; 3) comprehensive psychodiagnostic assessment of MDOs; 4) mental health treatment; 5) gradual/post-release monitoring/supervision and continuity of services; and 6) research evaluation of the program).

- Recommendation 8: Implement the use of a suicide risk assessment protocol, such as the ESR, as part of the admission process to the correctional centres. Train line staff, healthcare staff, and mental health professionals to understand and identify the risk factors associated with suicide and self-harm.
- Recommendation 9: Review and develop a uniform policy governing the identification and management of inmates at risk for self-harm and suicide.
- Recommendation 10: Develop an on-line system of maintaining information about whether inmates were screened for mental illness and whether the inmate is in need of mental health services. Establish and reaffirm information sharing and record keeping in the health files and progress logs.
- Recommendation 11: Review the need for and establish or further develop treatment programs and/or facilities that will be available to treat MDOs when they incarcerated (e.g., using a model such as that which is available on a limited basis at institutions like Ford Mountain).
- Recommendation 12: Work with affected agencies and Crown Counsel to establish protocols for diverting mentally ill offenders out of the criminal justice system when appropriate and to provide alternative community-based residential treatment programs for mentally ill offenders at regional levels.
- Recommendation 13: The Director of Mental Health Services should work with Corrections Administrators to develop mechanisms for increasing the involvement of corrections officers in the identification and management of mentally ill offenders.
- Recommendation 14: Establish and provide training to corrections officers and other staff regarding the identification and management of mentally ill offenders. The training should not only occur at the Justice Institute, but at the institutional level where the material may be geared toward the nature of offenders in the institution and the type of mental health services provided there.

Appendix A

Schedule of Services Review of Mental Health Services

The Contractor, in consultation with the Director of Health Services, Senior Nursing Consultant, and Directors of Programs will conduct a review of the need for mental health services to inmates, assess the current level and type of services, and recommend changes as required. More specifically, the Contractor will:

6. Assess the extent, range and type of mental disorders among the remanded and sentenced populations.
7. Review the current service delivery model for mentally disordered offenders (MDOs) in all correctional centres (including the special programs or units at Vancouver and Surrey Pretrial Centres) and estimate total resources deployed.
8. Review MDO service delivery model in other selected jurisdictions.
9. Recommend a service delivery model within available resources to meet the needs of MDO inmates. The model must:
 - (a) Define an overall acceptable level of assessment, treatment, accommodation, and follow up care for MDOs utilizing various mental health care service providers. The model must clearly outline what services will be provided in each centre;
 - (b) provide a consistent type and level of service among the secure custody centres;
 - (c) utilize available community-based resources to either provide services in centres or upon release of inmates to the community;
 - (d) describe the type of services to be provided by various mental health professionals including psychiatrists, psychologists, nurses or social workers;
 - (e) define the relationship between Branch mental health service providers and other agencies such as Forensic Psychiatric Services, Regional Health Boards and Community Mental Health Centres;
 - (f) define minimum assessment tests for suicide and violence screening;
 - (g) define the minimum standard of clinical and unit file documentation required of MDO inmates;

- (h) outline the role of correctional security staff in the management of MDOs, and
 - (i) specify the type of training required by security staff for dealing with MDOs.
10. Recommend approaches to automate clinical notes and other ways to improve communication among mental health care professionals and between health care staff and security staff.

Appendix B

A Review of the Relevant Literature⁶

The information reviewed in this Appendix provides an overview of the research and commentary that has been published concerning mentally ill offenders in jails. The review begins with an introduction to jails. This material will be of limited use to jail administrators, but will be valuable for mental health professionals and others with less familiarity in corrections. The review then continues with some commentary on the transition an inmate makes as he or she moves from the community to the jail. Next, the rationale for providing mental health services in correctional facilities is provided. This discussion includes an overview of studies that have considered the prevalence of mental illness among inmates. In addition, the impact of mental disorder on prisons and jails is presented, as well as a note about the legal requirements for mental health services in correctional facilities.

An Introduction to the Jail

Jails are the oldest and at one time were the only form of penal institution. In addition to their obvious role in detaining convicted defendants and those awaiting trial, jails have unfortunately also served as dumping grounds for other disenfranchised groups such as persons with mental disorders, substance abusers, runaway children, and the poor (Torrey et al., 1992). The mission of the modern jail has become somewhat more circumscribed as other institutions have been established to assist specific populations (e.g., prisons, mental health treatment facilities, detoxification centres, shelters, etc). Most jails, however, still serve as multi-purpose facilities for the jurisdictions in which they are located (Wayson, Funke, Familton, & Meyer, 1977).

Although people often use the terms 'jail' and 'prison' interchangeably, jails and prisons are very different institutions, with different purposes (Steadman, 1989). Jails serve as the entry point for the criminal justice system. They typically house three different categories of inmates: 1) those awaiting arraignment; 2) those who were denied bail and are being held until trial; and 3) those who received short sentences (in Canada, less than two years). By contrast, federal prisons serve to confine those inmates who receive a sentence of greater than two years.

A further distinction may be drawn between "pretrial" jails or institutions and those that house "sentenced" inmates. Pretrial facilities house inmates pending trial, or awaiting transfer to a sentenced facility. On occasion, of course, others may be housed in the pretrial facility (e.g., immigration holds, federal inmates who are appearing in court, etc.). By contrast, sentenced facilities house inmates who have received a fixed term of incarceration. It should be noted that some facilities house both pretrial and sentenced offenders. In those institutions, the distinction

⁶I am grateful to Ms. Tonia Nicholls for her assistance with obtaining relevant literature for this section of the report.

should be made between the status of the inmate – pretrial detainee or sentenced offender.

The jail's role in the criminal justice system and related social systems is especially important because it continues to serve as the entry point into various societal institutions (Gibbs, 1982). Because of their position as a "gateway" to incarceration, jails are the most common form of criminal detention. While it is clear that jails are an integral part of the criminal justice system, it is important to note that for the most part jails have emerged and developed in a very unsystematic manner. It has been observed that because it is out of public view and concern, "... the jail has evolved more by default than by plan" (National Advisory Commission on Criminal Justice Standards and Goals (NACCJS), 1985; p. 61).

As compared to prison, entry into the jail tends to be much more unexpected and disorganized (Gibbs, 1975; Wilerson, 1973). The inmate typically suffers an abrupt, unexpected loss of freedom and ability to communicate with others, and his or her movement and experience suddenly become dictated by an assortment of actors in the criminal justice and legal systems. Compounding this is the shuffling of the inmate from one stranger to another. Attempts to become comfortable or gain information about one's status are likely to be unsuccessful. These factors are presumably most salient for those who are being detained in jail for the first time. Moreover, jails have fixed and unbending rules, and inmates who will do best in jails are those who can abide by these rules. Inmates who are less able to understand and abide by these rules as a function of intoxication, symptoms of a mental disorder, or emotional upheaval are more likely to encounter difficulties in jail adjustment.

Typically, after being arrested, the inmate is transported to the jail by a police officer or deputy sheriff and turned over to correctional officers who "book" him or her into the jail. This procedure includes removing and accounting for the inmate's personal items. A health screening also occurs, which involves having a nurse administer a brief checklist, the purpose of which is to identify persons in need of treatment or more detailed assessment. Oftentimes, the checklists have several items devoted to mental state/mental health issues, although the degree to which these areas are covered varies widely between institutions. After a medical screening, the inmate is placed in a small individual cell or group cell with a number of strangers, some of whom may be mentally disordered, under the influence of, or withdrawing from alcohol or street drugs, or highly stressed themselves.

Upon entering jail, the inmate has lost control over most aspects of his or her life. In addition to the obvious restriction of contact with the outside world, the inmate is not even able to control such basic aspects of the surrounding environment such as light intensity, heat, or noise levels. At this point in time the inmate also has very limited control over the course of events and outcome of his or her life. Moreover, inmates often endure these stressors in a less than ideal physical environment in which strangers are constantly entering and exiting.

Crucial to understanding the nature of the jail environment is the transient nature of its population. Generally, the longest any inmate will remain in the jail is one year, but most

inmates will be detained there for a much shorter period of time while awaiting arraignment or trial (Bonta, Cormier, Peters, Gendreau, & Marquis, 1983). Accordingly, the inmates can be expected to have little invested in their environment or their relationships with staff or other inmates. This situation is distinguishable from the prison setting in which many inmates serve multiple year sentences. Accepting that prison is "home," at least for the remainder of their sentences, prison inmates might have a greater investment in the environment and their relationships with others. This will not be the case in jail though, as many inmates anticipate a short stay and no significant, extended contact with fellow detainees (Toch, 1975).

As indicated above, prosocial behaviour may not be rewarded in the jail setting, and anti-social behaviour may not be as maladaptive as in other settings (e.g., prisons). Thus, exposure to anti-social peers who are willing to victimize fellow inmates is a very significant stressor for inmates with and without mental illness. Of particular concern are findings reported by Torrey and his colleagues in their 1992 survey of jails indicating that inmates with mental illness may be at particular risk of maltreatment. Forty percent of the jail officials who responded to Torrey's survey indicated that inmates with mental illness were abused by other inmates. Such behaviour may be facilitated in jails where persons with mental illness are housed in special units, wear special uniforms, or line up for dispensing of psychiatric medications.

Inmates with particular mental disorders may also experience unique stressors as a result of their jailing that other, non-mentally ill inmates will not suffer. Some inmates with mental disorders will not have immediate access to psychotropic medications, as particular medications may not be available in the jail (e.g., clozapine) or as jail health care staff seek to verify treatment histories reported by inmates. This can lead to an obvious exacerbation of symptoms. Additionally, the jail experience itself can aggravate some symptoms of mental disorder. Torrey and his colleagues (1992) noted that arrest and jailing may aggravate and contribute to feelings of paranoia, while placement in isolation can exacerbate auditory hallucinations.

Together, the above makes clear that the newly incarcerated individual enters a stressful environment. The inmate cannot count on support from peers as prosocial behaviours are not particularly rewarding and may even be punished. Moreover, many of the detainee's coping mechanisms, both personal skills and resources gained from significant others, are made unavailable. Such a predicament occurs daily for thousands of individuals.

Compounding the above concerns is the fact that the functioning of jail inmates may be compromised by such factors as limited problem solving abilities, lack of education, alcohol or drug intoxication and/or addiction, asocial or antisocial behaviour, and mental disorder.

Studies indicate that between 6.5% and 10% of inmates suffer from a 'serious' mental illness, and another 15% to 40% of inmates suffer from a 'moderate' mental illness (Hodgins, 1995). These numbers raise the important question of whether correctional facilities are simply another forum for holding mentally ill and chemically dependent people. As discussed throughout this report, these figures pose difficulties for the inmates themselves as well as the correctional

facilities in which they are incarcerated. Further, there are a number of suicides in correctional facilities annually (Hayes, 1983). The purpose of this Article is to establish the need for correctional mental health services, discuss the legal standards for providing mental health services in jails and prisons in the United States, and review some of the empirical research concerning mentally disordered offenders (MDOs). The Article then presents and reviews a model for providing mental health services to jails and prisons. Throughout the Article the authors analyze existing policies and standards in light of the empirical research that exists regarding MDOs.

There is a general perception shared by jail health care administrators and jail mental health professionals that the number of persons with mental illness entering jails has increased over the years. Sixty-nine percent of jail administrators responding to the survey prepared by Torrey and his colleagues (1992) reported that the number of persons with mental illness who were entering jail had increased over the course of 10 years. Moreover, a number of commentators claim that the proportion of mentally disordered jail inmates is increasing (Gove, 1982; Johnson, 1983; Morgan, 1982; Teplin, 1983; Torrey et al., 1992). Upon reviewing the relevant literature Teplin (1983) concluded that "research literature, albeit methodologically flawed, offers at least modest support for the contention that the mentally ill are (now) being processed through the criminal justice system" (p. 54).

Given the differences between jails and prisons, and between pretrial and sentenced facilities, it is not surprising that the mental health issues that arise in these facilities also differ. Because most pretrial inmates are admitted shortly after arrest, the most important mental health issue involves careful screening of inmates to identify and manage those who are mentally ill and at risk of harming themselves or others. Aside from this, there often is little else that can be done by way of offering effective mental health intervention in pretrial centres or among pretrial detainees. Pretrial mental health programs should identify inmates with mental illnesses and provide a mechanism for diverting seriously mentally ill inmates to a secure mental health facility. In addition, they should serve as a conduit to community-based mental health services for those inmates who will not receive longer sentences. Finally, of course, the mental health needs of inmates must be met while they are incarcerated.

Those correctional facilities that house sentenced inmates must also provide some screening to identify those inmates with a mental illness, and to prevent mental health crisis situations from arising. In addition, though inmates' longer incarceration periods provide greater opportunity for the development and implementation of intervention programs. Moreover, some inmates will develop mental health problems or experience a change in mental health status while in prison (Hodgins, 1995). Therefore, programs in sentenced facilities must provide for formal or informal mechanisms for continuing to monitor inmates to identify mental illness during their entire period of incarceration.

Regardless of the different mental health issues that arise in pretrial and sentenced facilities, the inmate remains the chief concern. As a result, there are also many similarities

between mentally ill pretrial inmates and mentally ill sentenced inmates. Therefore, much of what is discussed in this report will apply to jails, prisons, and pretrial centres. Whenever necessary, however, the extent to which the issues between jails and prisons differ will be noted.

The Rationale for Providing Mental Health Services in Correctional Facilities

One would hope that concern for the physical and mental well-being of others would serve as ample justification for providing mental health services to all people-including those people who are incarcerated. Beyond a fundamental humanistic concern for the health of people, there are at least three separate rationales for providing mental health services to correctional inmates. First, the prevalence of mental illness among jail and prison inmates is far greater than that among the general population (Hodgins, 1995). Second, the provision of mental health services in correctional facilities helps further the goals of protecting society and maintaining a safe environment for correctional officers and inmates. Finally, legal requirements mandate screening inmates for illness (this arguably includes screening for mental illness) and providing a minimum level of health (and mental health) services to them. Each of these rationales is noted below.

Prevalence of Mental Illness Among Inmates⁷

The issue of inmates with mental disorders is a major concern among jail administrators and mental health professionals familiar with jails. Gibbs (1983) surveyed 39 jail managers and social service providers working in jails around the nation and found that mentally disordered inmates were their second most significant concern, jail overcrowding being the first. Jail administrators believe that persons with mental illness to be at significantly increased risk for suicide, violence, and abuse at the hands of others inmates than inmates without mental disorder. Jail administrators also see inmates with mental illness as requiring more attention from jail staff and much more likely to disrupt jail activities than their non-disordered counterparts.

A number of studies examining the prevalence of mental disorder in jail populations have been conducted. Rates of mental illness reported for jail inmates vary considerably among studies. Prevalence rates of mental illness among random samples of inmates vary between 3% (Petrich, 1976a) and 59% (Shuckit, Herrman and Shuckit, 1977; Kal, 1977), depending upon the criteria and diagnostic system used. Not surprisingly, higher prevalence rates have been obtained when samples have consisted only of those inmates referred by jail staff for mental health evaluations. In these cases, prevalence rates ranging from 24% (Nielsen, 1979) to 75% (Lamb &

⁷ Although discussion in this report is limited to mentally ill offenders, much of this information has some applicability to mentally retarded offenders. For example, Denkowski and Denkowski (1985) conducted a facility survey in 36 state prison systems and found 2% of offenders to be mentally retarded. Furthermore, mentally retarded offenders have a great deal of difficulty adjusting to prison and are often the victims of abuse while in prison (Denkowski, & Denkowski, 1985).

Grant, 1982) have been reported. Similar findings were reported by Allodi, Hedward, & Robertson (1977) in a Canadian study.

One method of estimating the prevalence of mental disorder among offenders is by 'facility survey (Jemelka & Trupin, 1989)." This involves determining the number of people in a particular institution or in an entire system-who according to official records are receiving some form of psychiatric treatment. The largest study of this type was conducted by Monahan and Steadman, who surveyed federal and state correctional and forensic psychiatric systems across the United States (Monahan & Steadman, 1983). They defined mental disorder according to medico-legal status: Forensic patients who were adjudicated unfit (i.e., incompetent) to stand trial or who were not guilty by reason of insanity (i.e., not criminally responsible on account of mental disorder), prisoners transferred to forensic hospitals for psychiatric treatment, and mentally disordered sex offenders (in those jurisdictions that had an applicable statute) were all considered mentally disordered offenders (MDOs).

Monahan and Steadman reported that about 6.5% of the 307,276 offenders included in the study were MDOs (Monahan & Steadman, 1983). Other facility surveys have reported similar results (Jemelka & Trupin, 1989). One obvious and severe limitation of this method is that medico-legal status tells us very little about the nature or severity of the mental health problems suffered by the MDOs. As well, its validity rests on the untenable assumption that all prisoners with significant mental disorder are correctly identified by agents of the criminal justice system. Consequently, it is likely that facility surveys underestimate the true prevalence of mental disorder in offenders.

An alternative to the facility survey method is known as the *field survey* (Hart & Hemphill, 1989). Here, researchers identify a sample of inmates at a correctional facility and assess them directly. This method is more costly than a facility survey, but can yield detailed psychodiagnostic information that is extremely useful for planning service delivery. Unfortunately, some researchers select their samples from inmates who are referred to the correctional mental health unit, operating on the assumption that all inmates with significant mental disorder self-refer to such units or are routinely detected and referred by correctional staff (Petrich, 1975). Other researchers rely on self-report inventories (i.e., self-administered questionnaires) to assess mental disorders. This procedure is of questionable validity given the poor literacy and lack of cooperative behaviour that is characteristic of many offenders.

The best field surveys have assessed a large, random sample of inmates using standardized rating scales and/or diagnostic interviews developed for use in epidemiological research. For example, one study examined 3,684 offenders in the New York state prison system (Steadman & Fabisiak, 1987). All inmates were rated on standardized scales of mental disorder and functional disability. About 8% of inmates were rated as having a "severe" psychiatric and/or functional disability. Sixteen percent of inmates were rated as having a 'moderate' disability, similar to that suffered by patients attending a psychiatric outpatient clinic. In total, 24% of inmates had a moderate to severe mental disorder.

Similar results have been obtained in other jurisdictions with other assessment procedures. In one study interviewers administered a structured diagnostic interview to 1,240 inmates of the Michigan state prison system (Neighbors, 1987). The interview yielded diagnoses of mental disorder based on the American Psychiatric Association's DSM-III criteria (APA, 1980). The prevalence of severe mental disorder (i.e., any active psychotic disorder) in the sample was 10.4%, and a further 38.4% had a less serious mood or anxiety disorder. Mental health professionals conducted follow-up interviews with 379 inmates and confirmed the high prevalence of severe mental disorder. They also rated 19.7% of the inmates as having 'severely impaired' social functioning and judged that 4.4% were in need of immediate psychiatric hospitalization.

In Oklahoma, another study sampled 1,080 consecutive admissions to the state prison system using a computerized assessment battery (James, 1980). The results indicated that 19% of admitted inmates were acutely suicidal, significantly mentally disordered, or both. A subsample of 174 inmates completed follow-up interviews with mental health professionals. Thirty-five percent were in need of immediate psychiatric treatment (2% inpatient, and 33% outpatient or day care).

Another study examined mental disorder among detainees in a large jail in Chicago. Lay-interviewers assessed the detainees using a structured diagnostic interview. The prevalence of severe mental disorder (schizophrenia, bipolar affective disorder, major depression) was 8.5% (Teplin & Swartz, 1989). This rate was significantly higher than that of community residents with similar demographic characteristics (e.g., age, gender, race, and socioeconomic status) (Teplin, 1991). Corrections staff failed to detect many cases of severe mental disorder during routine intake procedures (Teplin, 1990).

Research from provincial correctional facilities in British Columbia will be discussed below in the context of the review of correctional centres in British Columbia (see Table 2 and Table 3) (Ogloff, Roesch, & Hart, 1994; Ogloff, 1996; Roesch, 1995). Suffice it to say here that approximately 3%-5% of inmates have been found to suffer from psychotic illnesses, with an additional 10%-15% of inmates suffering from a major affective illness, such as major depression. In addition, a majority of inmates (60%-88%) suffer from a substance abuse disorder. Finally, many of these individuals have co-occurring disorders (e.g., schizophrenia and substance abuse), further compounding the mental health and social problems these individuals experience (Abram, 1990; Abram & Teplin, 1991).

The rates in any single facility do not necessarily reflect the rates expected in other facilities. Indeed, Teplin (1990) reviewed the research on the prevalence of mental disorder among jail detainees and reported rates ranging from 5% to 12% for severe mental disorder and from 16% to 67% for any mental illness. While the rates do vary, it is reasonable to assume that there are a substantial number of jail inmates who are in need of mental health services. Indeed, there is every reason to believe that the prevalence of mental illness would be greater in pretrial facilities than sentenced facilities since a number of mentally ill inmates who commit minor offences are

likely to be held in pretrial facilities for short periods of time.

The results of these large, methodologically-sound field surveys indicate that about 25% of prison and jail inmates in the United States suffer from a serious mental disorder (e.g., psychosis, severe depression or anxiety) that significantly impairs their social functioning and requires immediate treatment or management; about 5% to 10% of these inmates are severely impaired and require inpatient psychiatric care. Readers should not interpret this conclusion to mean that the majority of inmates are in good mental health. Indeed, over 90% have some form of diagnosable mental disorder (i.e., 50% to 75% of all offenders are diagnosed with antisocial personality disorder). The prevalence of substance use disorders is even higher (Ogloff, 1996; Ogloff et al., 1994; Roesch, 1995). However, many of the disorders common among inmates are chronic in nature, resulting in only mild or moderate disruption of psychosocial functioning, and are difficult or even impossible to treat (e.g., alcoholism, drug abuse, sexual deviation, personality disorder).

For illustrative purposes, key studies examining prevalence rates of mental disorder in the jails are presented in Table 1.

Table 1. The Prevalence of Mentally Disordered Persons in Jails: A Summary of Research Studies⁸

Study	Type of Sample	Findings
Bolton 1976	1,084 persons (sex not stated) from jails and juvenile detention centres from 5 counties	Adults: 6.7% Psychotic 9.3% Nonpsych. Disorder Juveniles: 2.9% Psychotic 20.6% Nonpsych. Disorder
Petrich 1976a	539 persons (80% male) referred for evaluation 42% felons	49% Psychotic 10% Depression 27% antisocial 43% Drug/Alcohol
Petrich 1976b	122 persons (84% male). referred for evaluation 80% felons	29% Schizophrenia 12% Depression 6% Mania 43% antisocial 70% Drug/Alcohol
Piotrowski, Lasacco, & Guze 1976	50 persons (86% male). selected from those referred for evaluation.	22% Schizophrenia 10% Bipolar 4% OBS

⁸The prevalence rates of mental disorder found in jails in British Columbia are presented in Table 2 and Table 3 in this report.

Swank & Winer 1976	445 persons (sex not stated) 41 felons, referred for evaluation	26% Psychosis 35% Personality Disorder 3% Neurosis
	100 persons (sex not stated) 71% felons, randomly selected	5% Psychosis 29% Personality Disorder 2% Neurosis
Kal 1977	Randomly selected.	50% DSM-III Diag., Females 63% DSM-III Diag., Males
Schuckit et al. 1977	199 persons (all male). Randomly selected, no felony convictions, no current drug charge.	3% Affective 16% Antisocial 27% Drug/Alcohol 48% Any Diagnosis
Nielson 1979	No sample size given, data based on % of those referred	24% Psychosis 47% Narcissistic Personality 4% OBS
Monahan & McDonough 1980	632 persons (82% male). Referred for evaluation, 55.5% misdemeanors	32% Schizophrenia 22% Personality Disorder
Whitmer 1980	500 persons (sex not stated) "In need of treatment," 50% felons (approx.)	Averaged 3 Prior Psych. Hospitalizations
Morgan 1981	Sheriff's perceptions of mental illness	estimates ranged from 4% to 50%
Lamb & Grant 1982	102 persons (all male). Randomly selected from referrals for evaluation. Drugs/alcohol excluded. 53% felons	75% Schizophrenia 22% Affective Disorders 2% Adjustment Disorders 2% OBS
Lamb & Grant 1983	101 persons (all female). randomly selected from referrals for evaluation Drug/alcohol excluded 37% felons	59% Schizophrenia 35% Affective Disorders 5% Adjustment Disorders 2% Dysthymia 2% Antisocial
Ninzy 1984	50 persons (74% male), volunteered to participate in study.	26% Psychosis 34% Drug/Alcohol 8% Personality Disorders 16% Neurosis 4% OBS
Virginia DMH 1984	171 persons (94% male) from 8 jails identified as mentally ill by staff.	40% Schizophrenia 47% Affective disorders 21% Mania 75% Mentally Ill
Glaser 1985	50 persons (sex not stated)	48% Schizophrenia

	referred for evaluation (Australian sample)	16% Affective Disorders 16% personality 8% OBS
Guy, Platt, Zwerling & Bullock 1985	486 persons (all male) were randomly selected. Only 96 of whom were given diagnostic interview.	12% Schizophrenia 4% Affective 9% Personality Disorders 5% Dysthymia 37% Drug/Alcohol 66% Psych. Problems
Valiserri, Carroll & Hartl 1986	769 persons (86% male). referred for evaluation.	17% Psychotic 83% Nonpsychotic 5.5% Predicted Morbidity
Teplin 1987	728 persons (all male). Randomly selected.	Life Current 3.8% 3.0% Schizophrenia 4.6% 3.1% Major Depression 2.2% 1.2% Mania 8.5% --- Dysthymia 21.0% 11.6% Neurosis 49.2% 48.4% Antisocial

Source: Teplin, L. A. (1991). The criminalization hypothesis: Myth, misnomer, or management strategy. In Shah, S. A., & Sales, B. D. (Eds.), Law and Mental Health: Major Developments and Research Needs (pp. 149-183). Rockville, MD: US Department of Health and Human Services.

There are numerous explanations for the different prevalence rates obtained. These include non-random selection of inmates (e.g., studying only those inmates referred for evaluation), small samples sizes, and varying criteria of mental disorder or illness (Gibbs, 1982; Teplin, 1983). Despite the methodological flaws of some of the research, it appears that mental disorder is at least as common, and probably far more common in jails than in the community (Teplin, 1983).

A number of observations can be made upon examining the results summarized in Table 1. Foremost, findings from studies examining randomly selected jail inmates suggest that there are large number of persons incarcerated in jails with significant mental disorders. Substantial numbers of inmates (perhaps as great as many as 10%) suffer from psychotic disorders and an even greater number suffer from anxiety or personality disorders.

Additionally, it appears that corrections officers may be most likely to identify inmates with psychotic disorders. This is suggested by the large percentage of inmates referred for mental health evaluations by jail staff who receive diagnoses of schizophrenia or affective disorder. This is of significance in terms of training corrections officers, who are front line personnel and therefore, are in the best position to identify inmates with mental disorders.

A number of authors have expressed a concern that depressed inmates are especially likely to go unnoticed by corrections officers, and thus, are not referred to mental health professionals for

evaluation and treatment. Depressed persons, unfortunately, may be considered "model inmates" by jailers. As a function of their depression, these inmates are unlikely to make demands upon staff or become involved in altercations with other inmates. Thus, they may not get referred for evaluation. Given the relationship between depression and self-injurious behaviour, however, the referral of these inmates is crucial for their well-being and the successful operation of the jail.

Regardless of whether their number is increasing, the research to date indicate that there are considerable numbers of mentally disordered individuals in the jails. Given the history of the provision of mental health services in jails, it is clear that this group has been underserved and neglected. Thus, steps should be taken to increase the availability of mental health services in jails (Steadman, McCarty, and Morrissey, 1986).

Interestingly, these results are very consistent with those reported by researchers working in other Western nations, including the United Kingdom, Australia, and Germany (Hodgins & Cote, 1990; Herman, 1991; Rasch & Stemmer-Lueck, 1985). The rate of serious mental disorder among inmates is significantly higher than the rate of serious mental disorder among community residents from similar socio-economic conditions (Teplin, 1990). This rate may increase over time due to deinstitutionalization and other factors (Pogrebin & Poole, 1987). Also, in most cases, the onset of mental disorder precedes the onset of criminal behaviour (Hodgins & Cote, 1990). Of course, it should be recognized that the stress of incarceration on its own may result in short- or even long-term psychological problems (Gibbs, 1987; Harding & Zimmerman, 1989; Teplin & Swartz, 1989).

The Impact of Mental Disorder in Prisons and Jails

If not properly treated or managed, MDOs can have a serious negative impact on the operation of a correctional facility. First, MDOs are more likely than other inmates to engage in 'disruptive' behaviour potentially harmful to themselves, other inmates, or correctional staff (Adams, 1986; Toch and Adams, 1986; Uhlig, 1976). Second, the high rate of suicide in correctional facilities (Hayes, 1983; Polvi, 1997) raises concerns not only for suicide victims, but for other inmates and correctional staff traumatized by the experience (Gibbs, 1983). Third, empirical research shows that MDOs are much more likely to be victimized (i.e., physically and/or sexually assaulted) in prisons than non-mentally disordered offenders, or people in the community (Cooley, 1992). Fourth, research shows that correctional officers view MDOs less favorably than other inmates, and feel the need for training in identifying and handling MDOs (Kropp, Cox, Roesch, & Eaves, 1989).

The Fourth Circuit Court of Appeal in the United States echoed many of the above concerns in Bowring v. Godwin, (1977) writing that:

The Fifth Circuit finds that deficiencies in health care and hygiene (including the provision of nominal psychological treatment) foster inmate frustration and resentment. These emotions, in turn, "thwart the purported goal of rehabilitation," and "Jeopardized

the ability of inmates to assimilate into the population at large when ultimately released." We agree with this proposition and note that it takes on added meaning when psychological illness (arguably traced to a failure or refusal to treat) becomes the ground for the denial of release itself (i.e., parole).

As the court accurately notes, the presence of untreated mental illness among offenders leads to both individual and institutional problems that may exacerbate a mentally ill inmate's mental health functioning, ultimately reducing the likelihood of the inmate receiving early or gradual release (Feder, 1994). For example, in a study of federal prison inmates in Canada, Porporino and Motiuk (1993), found that, when compared to non-MDOs, MDOs were more likely to have their supervised releases revoked (without committing new offences), were afforded fewer opportunities for early release – yet mental disorder, alone, did not account for an increase in recidivism.

Although a detailed policy review is beyond the scope of this report, there is little question that the primary and explicit goal of correctional systems is protection of the public through safe and efficient management of offender/clients (Dvoskin & Steadman, 1989). Dvoskin and Steadman find that one of the "core" principles of providing mental health services to offenders is to "help make the prison a safer place for both inmates and staff" (p. 205). Other goals, such as the reintegration of offenders into society through rehabilitation and treatment. However, it is important to recognize that these goals, even when observed are always subordinate to the first. Finally, we note that most correctional systems are under considerable pressure to carry out their duties in a fiscally responsible, cost-effective manner.

Providing appropriate mental services can help correctional systems fulfill their objectives by: (a) minimizing mental health problems suffered as a result of incarceration; (b) minimizing conflicts among inmates and between inmates and correctional staff., and (c) reducing substantially the post-release risk for recidivism of inmates with serious mental disorders.

Legal Requirements for Mental Health Services in Correctional Facilities

As the previous two sections show, the prevalence of mental illness among correctional inmates is high. If they are left unidentified and untreated, mentally ill inmates may have a disruptive impact on the correctional facility. Finally, the law requires that jail and prison inmates have a right to health care, and presumably mental health care, similar to that which would be available to them in the community. A comprehensive review of relevant statutes and cases is beyond the scope of this report. Nonetheless, it is worth noting here that the courts have yet to decide a case that directly addresses the extent to which prison and jail inmates have the right to psychological or psychiatric assessment and treatment.

Summary

The information presented above, demonstrates the high prevalence of MDOs in jails.

MDOs face significant hurdles as they endure the routine challenges of dealing with mental illness while incarcerated. In addition to being at risk for suicide MDOs are more likely to be victimized by other offenders, making their adjustment to jail or prison and their existence there particularly difficult. Apart from these difficulties, MDOs present a host of problems to other inmates, correctional staff and administrators. Safety and security in correctional facilities requires a structured routine with as little interruption to daily regimen possible. Given MDOs' potentially disruptive behaviour, they may jeopardize the routine of the correctional facility. Therefore, the presence of mentally ill inmates in correctional facilities creates many challenges and obstacles for offenders and staff alike. As a result, correctional officers perceive MDOs less favourably than other inmates and express the need for training to identify and manage MDOs. Although the law recognize an inmate's limited right to medical care and, at least by inference, to mental health care, the exact parameters of the quality and nature of care are unclear.

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Appendix C

Screening for Suicide Risk Among Jail Inmates: A Review of Risk Factors and Assessment Issues⁹

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The rate of suicide and self-harm among inmates is estimated to be three to nine times higher than the rate among the general population (Arboleda-Florez & Holley, 1988; Hayes, 1994; Topp, 1979) and US data indicate that suicide is the leading cause of death among inmates (Bonner, 1992). Inmates at pretrial jails are considered at an especially high risk for suicide. First, this population has high rates of suicide risk factors (e.g., substance abuse and impulsivity) (Hayes, 1994). Second, the pretrial environment itself (i.e., isolation from support networks, fear and shame of incarceration) increases risk for suicide (Felthous, 1994). Finally, mental illness is more prevalent among pretrial inmates as compared to the general population (Tien & Ogloff, 1993). A history of and/or presence of mental disorder is associated with greater suicide risk (Roy, 1985). Despite the fact that pretrial inmates as a group are at a relatively high risk for suicide, mental health intervention is neither necessary for nor available to all inmates who enter a pretrial centre. As a result, screening assessments should be used to identify pretrial inmates who are at serious risk for suicide.

Although suicide cannot be predicted (e.g., Roy, 1985), screening assessments provide a short-term estimate of risk based on the presence or absence of risk factors associated with suicide. Risk assessment research that attempts to predict violence toward others has emphasized the importance of static, clinical, and situational variables (e.g., Webster, Douglas, Eaves, & Hart, 1997). Suicide risk assessment also generally includes variables from these categories (for a review see Balon, 1987; Polvi, 1996; Roy, 1985). The relative importance of specific variables is equivocal; however, and it is difficult to test the relationship of risk variables to suicide. Even within a high-risk clinical population, research on suicide risk is limited by the relatively low base rate of suicide (Murphy, 1984) and the practical difficulties of collecting information about individuals' behaviour and psychological state just prior to the suicide attempt or completion (Busch, Clark, Fawcett, & Kravitz, 1993). Additional methodological concerns associated with the suicide risk literature include: (a) failure to use appropriate control groups, (b) reliance on retrospective information from collateral sources, and (c) an overemphasis of demographic rather than clinical variables (Balon, 1987; Pokorny, 1993). Finally, actuarial equations which include

⁹The "Estimate of Suicide Risk (ESR)" scale, developed for use in corrections (Polvi, 1996), is presented in Appendix D to this report.

¹⁰The review of risk factors and assessment issues regarding screening for suicide risk among jail inmates was prepared by Ms. Lindsey Jack, a doctoral student in the Graduate Program in Law and Psychology (Clinical Forensic Stream) at Simon Fraser University.

variables associated with suicide, often identify many false positives (Pokorny, 1993). Despite these limitations of suicide risk assessment, the available literature points to several variables that appear to be related to an increased risk for suicide.

Suicide screening assessments should include both static and dynamic variables. Historical/demographic variables related to suicide attempts or completions include: age, race, and sex, marital status, psychiatric history (i.e., affective disorder), history of substance abuse or dependence, history of previous suicide attempts, and mental illness (other than affective disorders) (Balon, 1987).

Clinical variables considered important for determining suicide risk include: suicidal ideation, intention, depression, hopelessness, psychosis, marital or economic crisis, serious physical illness, substance abuse, agitation and/or anger, and hopelessness (Balon, 1987). The lethality and proximity of previous attempts, presence of current plan, impulsivity, and accessibility of means to hurt self also are important (Sommers-Flanagan & Sommers-Flanagan, 1995).

Unfortunately, mental health screening in pretrial centres must be conducted under less than ideal clinical circumstances; each assessment must be brief, collateral information is rarely available, and inmates may be uncooperative or inaccessible (e.g., due to drug withdrawal). As a result, some inmates at risk for suicide will not be identified and others, who are not at high risk for suicide, may be flagged.

This report provides a brief review of the static and dynamic risk factors linked to risk for suicide. General risk factors will be identified and specific risk factors for inmates will be discussed. For a more detailed review of risk variables, the reader should refer to work by Polvi (1996) and Maris (1992). Finally, it should be noted that "comorbidity and interaction [of the risk factors] are crucial considerations" in assessing suicide risk . . . "there are different predictive or causal models for different types of suicide" (Maris, 1992, p. 16). This review will emphasize suicide risk factors associated with suicide among inmates housed in pretrial centres.

Historical Variables

As previously mentioned, historical variables that appear to be related to suicide attempts or completions include: age, race, and sex, marital status, psychiatric history (i.e., affective disorder), history of substance abuse or dependence, history of previous suicide attempts, and mental illness (other than affective disorders) (Balon, 1987).

Age, race, and sex

Based on research using community samples to identify demographic predictors of suicide, results indicate that rates of suicide are higher for men, whites, and individuals over 45 years of age (Garrison, 1992; Maris, 1991; Sommers-Flanagan & Sommers-Flanagan, 1995). Some research shows that older men are more likely to complete suicide, whereas, younger women are

more likely to attempt suicide (Chiles & Strosahl, 1995; Dingman & McGlashan, 1988). Among jail detainees, young age is a risk factor for suicide. As many inmates are young men; however, age and sex are not likely to be useful predictors of suicide among jail detainees (Felthous, 1994; Sherman & Morschauser, 1989).

Marital status

Research using community samples suggests that marital status is associated with suicide risk, in particular men who are divorced, widowed, separated, or who have never been married are at higher risk (Maris, 1992; Sommers-Flanagan & Sommers-Flanagan, 1995). Similarly, studies on jail detainees find the majority of those who commit suicide are single, separated, or divorced (Bonner, 1992; Felthous, 1994).

Psychiatric history

Psychiatric disorders are associated with a greater risk for suicide (Appleby, 1992). The risk for suicide among psychiatric inpatients and outpatients has been estimated as four to 20 times higher than risk for suicide among the general population (Tanney, 1992; Roy, 1985). In particular, depressive disorders and schizophrenia (Birket-Smith & Thusholt, 1993; Fawcett et al., 1990; King, 1994) are associated with suicide (Lesage et al., 1994; Murphy, 1984).

Higher rates of suicide also have been reported among patients with drug and alcohol dependence, as compared to suicide rates in the general population (Allebeck & Allgulander, 1990; for a review see Lester, 1992; Roy, 1985). Risk for suicide is greater among chronic alcoholics with lengthy abuse history, whereas, less is known about specific risk factors for drug dependent patients (Roy, 1985). Finally, individuals with substance abuse histories are more likely to develop depressive syndromes (Sherman & Morschauser, 1989), which may further increase their risk for suicide.

Mental disorder and other risk factors may interact to create increased risk. For example, patients with affective disorder may be particularly at risk for suicide when they are single, separated, divorced or widowed (see Roy, 1985). Among individuals with schizophrenia, those are actively psychotic (e.g., persecutory delusions, command hallucinations) and those who are depressed and/or hopeless about their illness are at greatest risk (Roy, 1985). Additionally, some research suggests that risk for suicide is greater for "young schizophrenic men at the beginning of their illness" (Roy, 1985, p. 230).

As discussed elsewhere in this report, the rate of mental disorder among inmates is higher than among the general population (Bonner, 1992; Cox, Landsberg, & Paravati, 1989; Felthous, 1994; Ogloff & Tien, 1993; Roesch, 1995). In one study the authors surveyed both prisons and jails and found that 186 individuals had committed suicide between 1958 and 1971. Of these 186 individuals, 70 had received past psychiatric treatment; 19 had a past diagnosis of major depressive episode, and 79 "had shown some tendency to depression in the past" (Topp, 1979, p. 25). Based on a longitudinal study, Liebling (1995) identified a subgroup of "psychiatrically ill" prisoners and jail detainees who committed suicide; these individuals made up 10-22% of the

total suicides between 1987 and 1992.

Prior suicide attempts

Persons who have previously attempted suicide are at a higher risk for subsequent attempts; this is especially true if the past attempt is within the last one to two years (Sherman & Morschauser, 1989; Sommers-Flanagan & Sommers-Flanagan, 1995). Resnick (1980) reported that nearly 75% of individuals who ultimately complete suicide, have made at least one previous attempt (as cited in Sommers-Flanagan & Sommers-Flanagan, 1995). When asking about past attempts, it is important to assess the individual's past intent (i.e., how lethal was the method, did he/she attempt to avoid detection, did he/she make any final arrangements) (Chiles & Strosahl, 1995). Additionally, the context of the past attempts is important, for example, whether past attempts occurred within the community and/or custody.

Family history of suicide

Family history of suicide is associated with an increased risk for suicide in psychiatric patients; this relationship holds for patients with schizophrenia, unipolar and bipolar affective disorders, depressive disorders, and personality disorders. Patients with affective disorders who have a family history of suicide are particularly at risk (Roy, 1985). Family history of suicide also is a risk factor for suicide among inmates (Sherman & Morschauser, 1989).

Clinical Factors

Clinical variables considered important for determining suicide risk include: suicidal ideation, intention, hopelessness, current mental disorder, recent significant loss or personal crisis, lack of social support, and/or social isolation, stressful life events and coping skills, aggression toward others, and current self-control (Balon, 1987). The lethality and proximity of previous attempts, presence of current plan, and accessibility of means to hurt self also are important (Sommers-Flanagan & Sommers-Flanagan, 1995).

Suicidal ideation

"Suicide ideations are defined as those who have thoughts and wishes of suicide, but have not yet acted on a plan to cause self-injury. Suicide ideation includes suicide threats, suicide preoccupations, direct expressions of the wish to die, and indirect indicators of suicide planning" (Weishaar & Beck, 1992, p. 468). When screening for suicide risk, interviewers should ask whether the inmate is experiencing (or has recently experienced) suicidal thoughts and feelings. If the inmate acknowledges current suicidal ideation, the frequency, duration, and intensity of the thoughts (Sommers-Flanagan & Sommers-Flanagan, 1995), as well as the inmate's reaction to having the thoughts (e.g., acceptance of thoughts or fear) should be assessed.

Suicidal intent

Suicidal intent is defined as the "intensity and pervasiveness of the wish to die" (Beck, 1986, p. 91, as cited in Weishaar & Beck, 1992). Intent can be assessed directly (e.g., asking the inmate to rate current intent on a 10 point scale) or indirectly by asking about suicide plans.

Suicide plans should be assessed in terms of: (a) specificity (i.e., more detailed plans are associated with a higher risk); (b) lethality (i.e., potentially more lethal plans are associated with a higher risk); (c) availability (i.e., how quickly could the individual carry out his/her plan); and (d) proximity (i.e., availability of helping resources) (Sommers-Flanagan & Sommers-Flanagan, 1995). Within the pretrial setting, proximity (i.e., means to hurt oneself) can be controlled (e.g., place the inmate under special observation); however, specificity, lethality, and availability of method should be assessed. If the inmate has previously attempted suicide, assessment of the past method is useful as it may indicate a likely future method (Weishaar & Beck, 1992). Hanging is the most common suicide method in correctional institutions (e.g., Felthous, 1994; Polvi, 1996). Past lethality also should be assessed; however, it may not be a reliable indicator of past intent (e.g., individuals who have not seriously hurt themselves may have had serious intent, but limited knowledge of lethality) (Weishaar & Beck, 1992).

Hopelessness

Hopelessness can be defined as "a state of negative expectancies" (Weishaar & Beck, 1992, p. 471). The association between hopelessness and suicidal ideation and intent has been strongly supported by research (see Weishaar & Beck, 1992; Polvi, 1996). In a sample of state prison inmates, for example, hopelessness and suicidal behaviour were significantly correlated (Ivanoff & Jang, 1991). If an inmate acknowledges significant thoughts or feelings of hopelessness, the frequency, intensity, and duration of these thoughts should be assessed. The interviewer also should ask about feelings of helplessness, worthlessness, and/or guilt (Sommers-Flanagan & Sommers-Flanagan, 1995).

Current mental illness and/or substance use

As previously reviewed, psychiatric history is related to suicide risk (e.g., Pokorny, 1992; Polvi, 1996; Roy, 1985). As such, individuals suffering current symptoms of mental disorder (e.g., depressed mood, substance abuse/dependence, and/or psychotic symptoms) will be at an increased risk for suicide (Maris, 1992; Polvi, 1996; Weishaar & Beck, 1992). Current symptomatology may increase risk by interfering with the individual's self-control and judgment. For example, depressed mood is associated characteristic negative thoughts, feelings of hopelessness, low self-concept, worthlessness and guilt (Sommers-Flanagan & Sommers-Flanagan, 1995; Weishaar & Beck, 1992). Finally, current alcohol and/or drug intoxication may cause mood changes and result in poor judgment (Weishaar & Beck, 1992). A national US survey of suicides in correctional institutions found that 60% of individuals who completed suicide in custody were under the influence of drugs and/or alcohol, 90% of this group committed suicide within the first 48 hours of incarceration (NCIA, 1981, as cited in Sherman & Morschauser, 1989). Withdrawal from drugs and/or alcohol also may impair judgment and increase suicide risk.

Significant loss, lack of social support, and/or social isolation

Recent significant losses (e.g., death of or separation from a loved one, economic losses, loss of status) are linked to greater suicide risk (Sommers-Flanagan & Sommers-Flanagan, 1992). This risk factor may be especially significant for offenders as they are isolated from supportive

others and may face potential loss of employment, long-term separation from significant others, loss of self-esteem, and/or loss of status in the community (Felthous, 1994; Sherman & Morschauser, 1989).

Stress and coping

Stressful life events have been linked to suicide risk; however, an individual's personality characteristics and his or her ability to cope with negative experiences or life events moderate this relationship (Yufit & Bongar, 1992). According to Bonner (1992), certain vulnerable individuals "are thought to be ill equipped to handle certain stressful life events, and over time may reach a psychological breaking point. At this breaking point, such vulnerable individuals . . . come to see suicide as perhaps the only viable option for dealing with intolerable life circumstances" (Bonner, 1992, p. 407). Individuals with limited coping skills and poor problem-solving abilities will have a greater suicide risk as they will have difficulty generating viable alternative solutions (Bonner, 1992). Among inmates, vulnerabilities such as social isolation, fear, psychiatric illness, and drug and/or alcohol intoxication, occur at relatively high rates. These vulnerabilities, combined with the stress of incarceration, can increase hopelessness and decrease coping (Bonner, 1992). Additionally, prior to his arrest and incarceration, the inmate already may have experienced a significant crisis, which may have prompted the criminal act itself (Felthous, 1994).

Aggression and anger

The association between aggression against others and suicide risk is equivocal. Limited research is available on this relationship (Hillard, 1995) and the studies that have been conducted provide conflicting results (e.g., Brown, Linnoila, & Goodwin, 1992; McNiel & Binder, 1988; Plutchik & van Praag, 1990). Among depressed individuals who are angry, agitated or anxious; however, suicide risk is increased. Resnick (1980) suggests these emotions "may indicate energy and motivation toward committing suicide" (as cited in Sommers-Flanagan & Sommers-Flanagan, 1995, p. 43). The presence of aggression and anger may be related to impulsivity and current self-control, which both are associated with an increased suicide risk (e.g., Polvi, 1996).

Current self-control

A history of impulsive behaviour has been linked to greater suicide risk (e.g., Sommers-Flanagan & Sommers-Flanagan, 1995; Polvi, 1996). Felthous (1994) notes that many inmates have "character weaknesses marked by impulsivity and low tolerance for frustration"; as a result, this group may be at heightened risk for suicide. Tendencies toward destructive substance abuse, verbal outbursts, and physical altercations are potentially indicative of impulse-control problems (Sommers-Flanagan & Sommers-Flanagan, 1995). To assess self-control, interviewers should ask direct questions about self-control and attempt to identify past patterns of behaviour (e.g., what has helped the individual maintain control in the past). As previously stated, current intoxication or withdrawal and mental illness may interfere with self-control. Finally, the presence of overcontrol also must be queried as these individuals "may be at extreme risk for suicide because once they begin to think about suicide, they become preoccupied or compulsive about acting on their thoughts" (Sommers-Flanagan & Sommers-Flanagan, 1995, p. 45).

The risk variables reviewed above are linked to suicide risk in both the general population and among inmates. The risk factors discussed in the following section are applicable to individuals in correctional settings, in particular inmates housed in jails.

Suicide Risk Factors Specific to Inmates

According to Hayes (1994), there are two primary causes of jail suicide; these are the jail environments, which are conducive to suicide, and the crisis situation of the inmate. These situation and person factors are further described as (Hayes, 1994, p. 156):

Characteristics of the jail environment

- Fear of the unknown
- Distrust of the authoritarian environment
- Lack of apparent control over the future
- Isolation from friends/significant others
- Shame of incarceration
- Dehumanizing aspects of incarceration

Predisposing factors within the inmate

- Recent excessive alcohol and/or drug use
- Recent loss of stabilizing resources
- Severe guilt/shame over alleged offence
- Current mental illness
- History of suicidal behaviour

Some of these risk factors (e.g., mental illness, history of suicidal behaviour) are associated with suicide in the general population as well. However, there are some risk factors that are specifically relevant for inmates.

Most inmates commit suicide by hanging between the hours of midnight and 5:00 am; most of these suicides occur within the first 24 hours of incarceration (Bonner, 1992; Hayes, 1994). The characteristics of the environment and vulnerability within the inmate (described above) may be most acute during this period. Based on his US research, Hayes notes that many suicides occur while the inmate is in isolation and under the influence of drugs and/or alcohol. Additionally, "many jail suicide victims are young and generally have been arrested for nonviolent, alcohol-related offenses" (Hayes, 1994, p. 156). This profile is generally corroborated by US survey research conducted in the late 1980s by the National Center on Institutions and Alternatives (Felthous, 1994).

History of arrest also is linked to suicide (Bonner, 1992); suicide rates are highest for two groups of offenders, those who have no prior arrest history and those who have been arrested four or more times (Sherman & Morschauser, 1989). Inmates who hold a position of respect within the community, appear to feel excessively embarrassed or ashamed, and/or who are charged with

a "shocking" crime (e.g., sexual assault of a child) also may be at increased risk for suicide (Sherman & Morschauser, 1989). Additionally, inmates who experience a change of status within the institutional hierarchy (e.g., move from general population to protective custody due to sexual assault charges) may be at risk. Finally, suicide risk may increase during specific times: (a) after a personal loss; (b) after inmate or significant other has developed a serious illness; (c) after any physical assault or threat of assault, especially sexual; (d) during holidays or special anniversaries; (e) pre- and post-sentencing; (f) after visits or phone calls; and (g) following a suicide in the facility or one highlighted in the media (Sherman & Morschauser, 1989, p. 124).

Some researchers suggest that suicide risk assessment should take into account "manipulative" versus "non-manipulative" suicidal behaviour. Based on a review of the available literature; however, Haycock (1992, as cited in Hayes, 1994, p. 157) concluded:

There are no reliable bases upon which we can differentiate 'manipulative' suicide attempts posing no threat to the inmate's life from those true 'non-manipulative' attempts which may end in death. The term 'manipulative' is simply useless in understanding, and destructive in attempting to manage, the suicidal behaviour of inmates (or of anybody else).

In a related vein, it is unrealistic to expect screening assessments, conducted in the absence of collateral information, to reliably discriminate those inmates who are truly at risk for suicide from those inmates who may be threatening suicide as a means to gain medication, special placement, or attention. Hayes (1994) also notes that if "manipulative" behaviour is ignored or discounted inmates may escalate their behaviour and die.

Conclusions

Given the high base rate of suicide among inmates as well as the relative vulnerability of this population, suicide risk assessments are essential. Such assessments should aim to identify the presence or absence of risk factors empirically linked to suicide. Although the historical risk factors (e.g., age, past suicide attempts) are largely static, the clinical variables are changeable. As a result, each inmate must be assessed (or re-assessed) upon entry to the pretrial facility. Past assessments of risk for suicide may or may not be correlated with current estimates of risk.

The screening assessment interview provides an estimate of short-term suicide risk. Inmates who are perceived to be at a moderate to high risk for suicide must be followed up as risk level can change (e.g., suicidal ideation can increase in frequency, intensity). Additionally, suicide risk estimates should not be based on the number of risk factors present, the interviewer must take into account the possible interaction between risk factors (e.g., alcohol intoxication combined with depression) and should be aware that certain risk factors can be deemed critical variables. The presence of one or two critical variables (even in the absence of other risk factors) may indicate high risk for suicide, for example, an inmate who lacks self-control and is currently psychotic (e.g., hearing voices that tell him to kill himself) would likely be considered at high

risk. Finally, screening assessments constitute only a first step in the attempt to reduce and/or prevent suicides in jail; the appropriate management and treatment of high risk inmates also are essential.

The Estimate of Suicide Risk (Polvi, 1996) represents a positive approach to screening inmates for risk of suicide. The ESR is presented in Appendix B. It should be noted that because the ESR was developed more with sentenced inmates in mind, two of the items need to be modified for use with a pretrial or jail population. First, for item 8, we suggest substituting **seriousness of crime and point in the criminal justice process** for sentence length. In particular, attention must be paid to whether the inmate has a realistic understanding of the situation and whether the inmate is able to cope accordingly. Second, with item 9, **No past experience with the criminal justice system, or change in status** should be substituted for time served in sentence.

The ESR is being used in the mental health review of the 400 offenders that is being conducted and the results will provide some initial information about the frequency with which some of the risk items are endorsed. Finally, in the longer term, it will be possible to obtain information about the predictive validity of the ESR.

Appendix D Estimate of Suicide Risk (ESR)

Estimate of Suicide Risk (ESR)

Name _____ Examiner _____ Date _____
Age _____ Sex _____ Institution _____

PART 1. ASSESSMENT

Score each item as 0, 1, or 2. Items with asterisks are especially important to risk.

Historical and Actuarial Factors	0	1	2
1. Psychiatric history			
2. History of alcohol or drug abuse			
3. Prior suicide attempt(s)			
4. History of impulsive behavior			
5. Family history of suicide			
6. Age			
7. Marital status			
8. Sentence length			
9. Time served in sentence			
Clinical Factors			
10. Suicidal ideation			
11. Suicidal intent*			
12. Suicidal plan*			
13. Hopelessness*			
14. Sudden change in psychological functioning*			
15. Stress, vulnerability and coping			
16. Depressive symptomatology			
17. Current use of alcohol or drugs			
18. Psychotic symptoms (e.g., delusions)			
19. Physical isolation (e.g., segregation/dissociation)			
20. Psychosocial isolation			
Column Totals			
Total (Columns 0, 1, and 2)			

PART 2. ACTION

Security supervisor notified? Yes ___ No ___
Monitoring recommended? Yes ___ No ___
If yes, indicate frequency: Continuous ___ 15 minutes ___ 30 minutes ___
Other _____
Referral made to another mental health professional? Yes ___ No ___
If yes, Psychiatrist _____ Other _____
Other recommendations _____
Date of exam _____ Time _____ Examiner's signature _____



Appendix E

British Columbia Corrections Branch

Mental Health Services Review Screening Manual¹¹

The information in this manual is to be obtained for every inmate who enters the jail. In addition, the Estimate of Suicide Risk, the Test of Nonverbal Intelligence, and the "H" (Historical) scale of the HCR-20 should be used in the screening process where indicated.

This review is being conducted as part of a review of mental health services for the BC Corrections Branch. In particular, we are charged to:

Assess the extent, range and type of mental disorders among the remanded and sentenced populations.

An offender who reports experiencing multiple stressors (e.g., unemployment, a recently failed relationship, financial problems, a serious criminal charge, substance abuse) will generally be considered a higher priority for mental health services than someone with fewer stressors. However, the presence of stressors is only one aspect guiding the decision to refer the inmate for mental health services. Other factors guiding the decision to refer include the offender's perceived lack of social support, significant disturbances of mood (e.g., anxiety, depression, irritability, or manic symptoms), his perceived lack of options, and how the inmate reacted to similar past stressors (e.g., did he attempt suicide, or did he approach others for help)?

General information. If the respondent answers a question in the psychopathological direction, further details are obtained (e.g., dates or ages of occurrences; frequency, duration, and severity of problems). Because collateral information is usually not available, the information available is typically completed from offender self-reports. If collateral information conflicts with information obtained by offender self-reports, the least favorable information about the offender is generally assumed to be correct and is used for coding purposes. (This method of coding is based on the assumption that the offender will tend to present himself in a favorable manner, unless he is experiencing emotional distress significant enough to request treatment. Of course, interviewers should be aware that the inmate may attempt to appear significantly disturbed in order to receive prescription medications).

Interview Questions

At the outset, explain that these interviews are being conducted at the request of Corrections to determine how well-adjusted people are who are coming into the jails. In particular, the information will be used to plan for mental health and substance abuse services for inmates.

BACKGROUND INFORMATION

¹¹Much of the information in this manual is drawn from the "Surrey Pretrial Services Centre (SPSC) Mental Health Intake Interview Questions and Coding Criteria."

How old are you?

Were you born in Canada? (If "no": Where were you born? What year did you come to Canada?)

What is your current charge you're in here for? Have you gone to court on that charge yet? (If "yes": Were you sentenced? How much time did you get?)

About how many times have you been to prison or jail? What was the longest sentence you received? Do you have any violent offenses on your criminal record?

Have you ever had any problems with inmates or staff? Have you ever been in segregation/the hole? Have you every been to Protective Custody? (If "yes": How many times? For what? For how long?)

SOCIAL ADJUSTMENT

Marital

Are you currently married or common-law? Have you ever been married or common-law?

How would you say things are between you and your partner?

How many physical or verbal fights would you and your partner have in an average month/week/year? Have these arguments ever gotten to the point that either one of you pushed, hit, or punched the other?

Do you have any assaults against your partner on your criminal record? (If the current charge is an assault, and the inmate has not volunteered details, ask if the assault was against his wife/common-law/partner.)

Coding:

0 (Very Poor) = inmate said he has frequent verbal fights with his partner; offender said he (or his partner) have been physically abusive to one another on several occasions

1 (Poor) = said he and his partner have had a moderate number of verbal fights; reported no more than two physical altercation(s)

2 (Fair) = described his relationship with his partner as "okay"

3 (Stable) = said his relationship is "excellent," and he and his partner have been involved for at least six months

4 (Superior) = said he and his partner have a stable relationship, and they have been involved for a number of years with few if any physical or verbal exchanges, partner is supportive

5 (N/A) = said he was not currently involved in a relationship.

Social/Interpersonal

Do you have friends that you can go to for support? (If inmate asks for clarification, ask if he has friends that he can go to if he needs to talk to someone or if he needs emotional support.)

Determine the quality of these interpersonal relationships. Do you usually prefer to be around other people, or do you prefer to be by yourself? (If the inmate asks for clarification, ask if

he is a loner, or if he is sociable and outgoing.)

Coding:

0 (Very Poor) = inmate presented as very socially awkward, and may be at risk for victimization by other inmates

1 (Poor) = inmate described himself as a "loner," but said he can relate adequately with others when he wants to, inmate said he has no friends and/or doesn't need them

2 (Fair) = said he likes to be around others, or said he like to be both alone and with others at different times, inmate said he has some friends

3 (Stable) = described himself as "outgoing"; involved in several social clubs or activities, inmate said he has friends and that he would go to them for support

4 (Superior) = said he is very comfortable socially with others, often a group leader, appeared sincere.

Vocational

What was the highest grade you completed?

- Have you been working in the past month? (If "yes": What do you do? How long have you been there? Is the work full-time or part-time?) When was the last time you worked?
- Have you ever been on Social Assistance? How many times? When was the most recent time you were on Social Assistance? Why were you on Social Assistance (e.g., he was waiting for Unemployment Insurance to begin, he was between seasonal jobs, he has never been steadily employed).

Coding:

0 (Very Poor) = said he is currently unemployed, has collected Social Assistance most of his life, has little employment ambition, education, or skills

1 (Poor) = said he was recently laid-off or fired, may be on Unemployment Insurance, said he has some possible job prospects, may have been on Social Assistance several time

2 (Fair) = said he was employed for up to six months with the same company, or attended school full-time

3 (Stable) = said he was employed for more than six months with the same company, and said he plans to continue working there

4 (Superior) = said he worked many years with the same company

5 (N/A) = inmate was not asked the vocation question(s); inmate has been incarcerated for most of the past 6 months; inmate has been on CIBC disability pay for a number of years and is no longer able to work.

Residence

What city do you currently live in? What kind of place do you live in (e.g., a house, apartment, basement suite, hotel)? Do you live there by yourself or with other people? How long have you lived in that particular place? Why did you move from your other residence?

Coding:

0 (Very Poor) = said he lives on the street

1 (Poor) = said he lives in a hotel; said he lives with his friends and he pays little or no rent; said he lives at home, is > 18 years -old, and makes little contribution

2 (fair) = said he lives at home and is < 18 years-old; said he has lived in the same residence for up to six months

3 (Stable) = said he has lived in the same residence for more than six months, and does not plan to move soon

4 (Superior) = said he has lived in the same residence for a number of years; said he owns his own house

5 (N/A) = inmate was not asked the residence questions(s); inmate has been incarcerated for most of the past 6 months.

Family of Origin

Are your parents still alive? About how much contact do you have with them? How would you say you get along with them?

Coding:

0 (Very Poor) = said he has no contact with his parents or other family members

1 (Poor) = said he has little contact with his parents/siblings, or said he does not get along with them

2 (fair) = said he contacts his parents/siblings at least once a month, and said he gets along "okay" with them

3 (Stable) = said he and his parents/siblings have weekly contact, and that they get along well

4 (Superior) = said he and his parents/siblings have at least weekly contact, described his parents as very supportive, and said they get along "excellent."

5 (N/A) = inmate was not asked the family of origin questions; inmate said that his parents are deceased

SUBSTANCE USE/ABUSE

"CURRENT" was coded for alcohol or drug use in the past month, "LIFETIME" was coded for alcohol or drug use over his lifetime

Alcohol Use/Abuse

In the past month, how many days a week did you drink? What did you drink (e.g., beer, hard alcohol, wine, ginseng or Aqua Velva)? How much did you drink each time? In the past was your alcohol use more, less, or about the same? Has alcohol ever been a problem for you? [If "yes": How much did you drink? Have you ever been a binge drinker?] Describe your heaviest period of alcohol use. Has there been any time, including right now, when you would have considered yourself to be an alcoholic? Has anyone ever said they thought you had a problem with alcohol? Has alcohol use ever interfered with your work or relationships? Have you ever had physical signs of withdrawal because you stopped using alcohol (e.g., DT's, withdrawal seizures)? Have you ever been charged with impaired driving?

Coding:

0 (Nonuser) = said he never drinks alcohol, or tried alcohol, didn't like it, and never continued drinking

1 (User) = said he drinks no more than two or three drinks two or three times a week

2 (Abuser) = said he drinks to get drunk; said he drinks six drinks or more twice a week; said drinking has contributed to problems in a relationship, work, or he has been charged with impaired driving once

3 (Severe Abuser/Dependent) = said he has physiological signs of withdrawal; drinks Ginseng, Aqua Velva, Lysol, or other methyl alcohol products; said he has had treatment for alcohol abuse; said he has suffered withdrawal seizures or hallucinations from alcohol abuse.

Drug Use/Abuse

In the past month, what types of drugs have you used? How often did you use each drug? How much did you use?

- In the past was your drug use more, less, or about the same? Have drugs ever been a problem for you? Describe your heaviest period of drug use. Have you ever been addicted to drugs (If "yes": For how long)?
- Has anyone ever said they thought you had a problem with drugs? Has drug use ever interfered with your work or relationships?
- Have you ever had any physical signs of withdrawal because you stopped using drugs (e.g., shakes, sweating)?
- Have you ever been charged with drug-related offenses (e.g., possession, trafficking)?

Coding:

0 (Nonuser) = said he has never used drugs, or tried it, didn't like it, and never used

drugs again

1 (User) = said he has used drugs on a recreational (i.e., occasional) basis, and no more than once a week

2 (Abuser) = said he frequently uses marijuana, or uses other drugs moderately; said drugs have contributed to problems in a relationship, work, or school

3 (Severe Abuser/Dependent) = said he has often used drugs intravenously; said he has committed crimes (e.g., armed robberies) to support his drug habit.

Past Alcohol/Drug Treatment

The offender was asked if he had even been in any of the following treatment programs for problems with drugs or alcohol: Detox, a residential treatment program, Native Healing, community counseling, or correctional facility treatment. Affirmative responses were coded "1" (Yes), negative responses were coded "0" (No), and if the question was not asked, or the offender refused to answer the question, the item was coded "9" (No information).

MENTAL HEALTH CONTACTS

If offender denied any mental health contacts--for assessment, treatments, or admissions for psychiatric problems--the categories were coded "0" (Does Not Apply). If he reported mental health contacts, the appropriate category or categories were coded "1."

Assessment

In the past month, have you seen a psychologist or psychiatrist? Have you ever seen a therapist, counselor, psychologist, or psychiatrist? [If "yes": Why did you see them? Did you go for assessment or treatment (e.g., Was a report written-up? What were the conclusions/diagnoses? How often did you see the therapist, and for how long - e.g., once a week for four months)? How long did the symptoms last? Did the symptoms reappear?]

Coded as "1" if he said he saw a therapist for an assessment, or said he saw a therapist for one session but he could not recall what the session was for. Routine mental health assessments (e.g., seeing Intake Interviewers during routine admissions to the jail) were not coded "1."

Outpatient

Have you ever had any medications for your nerves or to help you sleep, relax, or calm down? (If "yes": Was it prescribed? When was the last time you were on these medications?)

- Have you ever been on any medications to help straighten out your thoughts (i.e., antipsychotic medications)? When was the last time you were on these medications?

Coded "1" if he said he saw a therapist for treatment on an outpatient basis, or said he was prescribed medication on an outpatient basis

Inpatient (< 6 months) and Institutional (> 6 months)

Have you ever been institutionalized for any mental problems or concerns? (If "yes": Where? For how long? For what?)

Inpatient (< 6 months) = "1" if he said he was in an inpatient mental health facility/psychiatric ward for less than six months at a time; Institutional = "1" if he said he was institutionalized for mental health problems for more than six months at a time.

INSTITUTIONAL RISKS

Suicide/Self-Harm

In the past few weeks, including right now, have you had thoughts about wanting to harm or kill yourself? (If "yes": Are you concerned you may actually try to harm or kill yourself, or are these just thoughts? Have you thought about how you would go about harming or killing yourself?)

- Have you ever had thoughts about wanting to harm or kill yourself? Have you ever made any suicide attempts? (If "yes": When was the most recent time you tried to harm or kill yourself? What was the context (e.g., during past incarcerations or failed relationships)? Were you actually trying to harm or kill yourself, or were you hoping to get something/attention? How many suicide attempts have you made? When were the other attempts? What did you do?)
- Do you consider yourself to be a suicide risk while in jail? (Note: observe, and inquire about, burns, scars, or slashes, particularly those on his wrists, arms, or neck.)

Coding:

0 (None) = said he does not have suicidal ideation or intent

1 (Low) = said he has some suicidal ideation without intent

2 (Medium) = said he has suicidal ideation with intent, and has a clear suicide plan that would take place outside of the jail (i.e., overdose, jumping off bridge, shooting himself); has harmed himself (e.g., deep slashes on arms, wrists, or neck); appeared profoundly depressed

3 (High) = said he is currently having suicidal ideation, and has a plan to kill himself while in jail (or is able to carry out his plan in jail (i.e., hanging self, slashing); inmate admits that he is at risk to harm himself while in jail.

Violence

In the past month, have you had thoughts about wanting to harm or kill other people? (If "yes":

Is there a concern you may actually try to harm or kill someone while in jail? If the inmate has incompatibles in jail, does the S.C.O. know?)

- Would you say you get angry easily, or that it takes quite a bit to get you angry?
- When was the last time you were in a physical fight? About how many physical fights do

you get into each month/week/year?

Coding:

0 (None) = said he is even-tempered, gets along well with others, and rarely if ever fights; said he has not fought in a number of years (e.g., last fought in elementary school)

1 (Low) = said he has been in no more than two fights, initiated by another person; said his last fight was some time ago

2 (Medium) = said he has fought a number of times, and initiated several fights himself; appeared irritable and short-tempered in the interview; said he has one assault on his criminal record; said he is angered easily but rarely fights

3 (High) = said he fights often, may have had a fight in the past year; said he has several assaults on his criminal record; said he is angered easily and has been in a number of fights recently.

Poor Adjustment

Is there any reason you might have problems with inmates or staff in this jail?

Coding:

0 (None) = has been to jail before, and said he got along well with inmates and staff, and posed no adjustment concerns

1 (Low) = may not have been to jail before, and appeared mildly anxious about his first incarceration

2 (Medium) = appeared moderately anxious about being in jail; may have presented as moderately awkward socially; is in withdrawal and presents as very irritable

3 (High) = presented as very socially awkward, and would likely be victimized by other inmates; said he has been victimized by others while in jail before; is intellectually challenged, and others perceive him as loud and/or irritating.

MENTAL STATUS AND OBSERVATIONS (BPRS)

This section uses the Brief Psychiatric Rating Scale (BPRS) for obtaining mental status information. The following are additional interview questions for coding the BPRS.

Because items 18, 23, and 24 on the BPRS are to be rated from the patient's behavior and speech observed during the interview, they are completed immediately after interviewing the offender. Because items 1 to 10, and 19 to 22 are to be rated from the patient's answers to the interviewer's questions, they should be completed as soon as possible, sometimes at the end of the night. See The Surrey Pretrial Mental Health Project manuscript, dated December 10, 1991, or *Schizophrenia Bulletin*, 1986, 4, for BPRS rating details.

BPRS Item 1

Have you had any problems or concerns about your physical health? (If "yes": Did you let the nurse know about this? -If he did not tell the nurse about any important physical complaints, and he has already seen her for the Physical Health Intake Interview, be sure to let the nurse know.)

BPRS Item 2

Have you been more anxious, tense, nervous, or upset than usual in the last two weeks? How do you know you have been more anxious than usual (e.g., increased heart rate, sweating, choking sensations, cannot concentrate)? Has this interfered with your ability to do things (e.g., work, socialize)?

BPRS Item 3

Have you been depressed, sad, or down more than usual in the last couple of weeks? How do you know you have been depressed more than usual? Are you able to switch your thoughts to more pleasant topics when you want to? Have you had any problems eating, sleeping, or concentrating? Has this interfered with your ability to do things (e.g., work, socialize)? Has your weight changed recently?

BPRS Item 4

Is there anything you wish you'd done differently in your life? Do you have any regrets that stand out? Have you been bothered by overwhelming feelings of guilt within the last two weeks? (If "yes": What does he regret? If inmate mentions a few regrets, ask: Of these, what do you regret most?) Attempted to establish the degree of his regret/guilt.

BPRS Item 5

Have you gotten into any fights or arguments within the last two weeks? (If "yes": Who has he fought with? Has he been in a number of minor arguments, one serious argument, any physical altercations?) Attempt to establish the degree of hostility he has been experiencing within the last two weeks.

BPRS Item 6

Have you felt suspicious of anyone in the last two weeks? Have you felt like anyone has been watching you or trying to harm you in any way in the last few weeks? (If "yes": Who have you been suspicious of? Why do you think that person may be trying to hurt you?) Attempt to determine the degree of unusualness of the suspicion.

BPRS Item 7

Have events taken on any special meanings for you (personally) in the last few weeks? Do you get messages from the radio, television, or newspapers? Do you have any unusual thoughts? Do other people think that you have unusual thoughts? (If "yes": What are these thoughts? What type of messages?) Attempt to determine if the inmate is experiencing any unusual thought

content.

BPRS Item 8

Do you have any special powers or abilities? Can you do things that other people cannot? (If "yes": What are these special abilities? Can anyone else do these things?) Attempt to determine the extent to which the inmate thinks that his or her powers are unique. NB: Many Native offenders state that they have visions and can tell the future--assess this in the context of other Natives to determine the extent to which this inmate thinks he or she is special.

BPRS Item 9

Sometimes people's minds play tricks on them, and they think they see, hear, or smell things that aren't really there. Have you had this experience before? (If "yes": Have you ever had these experiences when sober/straight?)

BPRS Item 10

What is today's date? What is the name of this place?

BPRS Item 20

According to the *Schizophrenia Bulletin* article, this self-neglect item is coded according to the personal hygiene, physical appearance, and eating behavior of the individual. Self-neglect upon admission to jail is sometimes difficult to complete accurately because by the time the Intake Interviewer sees the offender he has showered, cleaned-up, and changed into institutional clothing. Therefore, admissions photographs taken before the offender has showered and changed can be used to assess amount of self-neglect and include information on dental care (e.g., were his teeth stained or discolored?), nail care (e.g., were his nails trimmed and clean?), and hair care (e.g., was his hair lengthy, uncombed, and/or greasy?). If the offender is a substance abuser, are there physical signs of abuse (e.g., weight loss or gaunt, suggesting the substance abuse had an impact on his eating behaviors; track marks from intravenous substance use)?

BPRS Item 21

Has anyone become concerned about certain behaviors you may have elicited in the last few weeks? Has anyone become afraid of you because of certain things that you have done? [if "yes": What things have others become concerned about? Do they ever say that these things are unusual or not normal?] Attempt to determine whether the inmate has elicited any bizarre behaviors in the past few weeks.

BPRS Item 22

Have you felt really good or really hyper in the past few weeks for no reason? Have others said that you were manic? Has anyone said that you were not acting like your normal self?

ADDITIONAL CODING CRITERIA FOR

REGISTRATION/INTAKE SCREENING FORM
MENTALLY DISORDERED OFFENDER CLASSIFICATIONS

In general, these MDO Categories were not found to be particularly useful because they were believed to have either been endorsed too infrequently (e.g., Categories I, II, and V) or too frequently (e.g., Category III), to provide much discrimination between offenders. These five Categories were coded as "0" (i.e., not present) unless the criteria described below were met.

Category I - Certifiable

People who suffer from severe psychotic illnesses characterized by thought disorders, delusions, hallucinations, or profound abnormalities of mood (i.e., out of touch with reality); and who present a threat to self or others; may or may not be found fit (competent) to stand trial; may or may not be competent to give informed consent.

Category II - Mentally Ill, Not Certifiable

Persons who are seriously disturbed and show clear signs of mental illness, but do not present an immediate risk to self or others; most would be fit to stand trial and competent to make informed consent decisions. Individuals currently on psychotropic medication(s), and/or individuals with regular mental health contacts for serious mental health problems, are coded "1" (i.e., present).

Category III - Borderline Mentally Ill

People who may show only borderline features of mental illness, but who may have multiple problems that aggravate their situations and disturb others (e.g., organic disorders, substance abuse, borderline mental handicap); these people may be considered "dysfunctional" to the extent that they may display an array of problems including mood disorders, lack of control, emotional lability, and suicidal ideation.

Category IV - Situational/Short Term Disorders

These individuals are not seriously disturbed (i.e., they lack the features of a major mental illness), but are generally reacting to some pressure in their lives; they develop acute adjustment problems that may be reactive in nature and are generally treatable; their main symptoms are likely to be anxiety or depression, and while they are not likely to pose a threat to others, they may present, for short periods, a high risk of danger to themselves. Individuals with few or no previous contacts with mental health professionals, but who were currently "seriously disturbed" because of recent stressors (e.g., marital break-up, serious financial difficulties, current involvement with the law), may be coded "1" (i.e., present).

Category V - Intellectually Challenged

Because no formal measures of intelligence or adaptive functioning are available at the intake assessment, only individuals presenting with clear deficiencies in intellectual or adaptive functioning (e.g., mentally retarded), or presenting as very awkward and socially inappropriate

(e.g., likely to be victimized by other inmates), should receive scores of "1" (i.e., present). Those persons with suspected, but not clear, deficiencies in intellectual or adaptive functioning may be coded "?".

MANAGEMENT RECOMMENDATIONS

Individuals who did not express an interest in receiving, and who did not appear to require, any of the services listed below were coded "1" (Applies) in the "None/Routine Intake" category.

Individuals who expressed an interest in receiving, or who appeared to require, services listed below were coded "1" (Applies) under the appropriate category or categories. One or more Management Recommendations categories, including "None/Routine Intake," were coded "1" (Applies) for each offender.

None/Routine Intake. Most offenders will be coded "1" because they are "routine intakes."

Monitor/Reassess. Offenders presenting with significant mental health concerns are coded "1". They may display--or acknowledge--disorders of thought, affect, or perception, or admit significant suicidal or homicidal concerns (e.g., ideation with past attempts). Because suicidal ideation without intent or plans is relatively common, suicidal ideation by itself is not usually coded "1" unless the inmate also presents with symptoms of depression (e.g., sad affect, changes in sleep or appetite, ruminating about problems).

Evaluate for Treatment. Offenders presenting with significant mental health concerns that may benefit from treatment are coded "1." This category includes inmates posing a danger to themselves or others, those saying they are experiencing notable stressors, those presenting with important psychological symptoms (e.g., depression, anxiety), and those who request treatment.

Evaluate for Medications. Any inmate currently on psychotropic medication should be referred to the Mental Health Program. Offenders requesting psychotropic medications, or those whom the Intake Interviewer considers prospective candidates for psychotropic medications (e.g., the offender is psychotic, markedly anxious, or depressed), are coded "1." These patients are referred to the Mental Health Program for a medication screening. Depending on the results of the medication/ psychological screening, the offender may be evaluated by a psychiatrist to determine if psychotropic medications will be prescribed. Because psychiatrists tend to prescribe medications conservatively, patients who present with mild psychological symptoms are not usually coded "1." Offenders with chronic psychiatric histories, and those who have recently been prescribed psychotropic medications, are usually coded "1." Patients requiring medications for medical reasons, rather than for psychological or psychiatric concerns, are not coded "1" here. Instead, the patient is referred to the intake nurse or doctor (e.g., so medical staff can evaluate the appropriateness of prescribing anti-withdrawal medications for drug addicts or chronic alcoholics).

Evaluate for Release Planning. Offenders requesting assistance to help them make a smooth transition back into the community (e.g., find a job or an apartment), or plan for release, are coded "1."

Segregation/Isolation. Offenders with mental illnesses that need to be separated from other offenders are coded "1." This category is reserved primarily for actively psychotic or highly suicidal offenders requiring placement in medical isolation glass cells.

Suicide Watch. This category includes only inmates posing a very high suicide risk that need almost constant monitoring and supervision.

Evaluate for Mental Health Act Committal. Only offenders clearly meeting the Mentally Disordered Offender Category I (Certifiable; see description above) are coded "1."

Literacy/Language Problems. Non-English speaking offenders are coded "1." If an appropriate interpreter cannot be located, and the inmate does not clearly appear to have any mental health concerns, the following phrase is to be written in his clinical/progress note: "Inmate indicated he was unable to speak English, so he was only briefly interviewed. He did not appear to present with significant mental health concerns."

Other: Offenders requesting mental health services not listed above, or requesting services unrelated to mental health, are coded "1." These often include requests by the offender to see a Social Worker about obtaining a Social Assistance cheque, or requests to see an optometrist or ophthalmologist for new eyeglasses.

Drug/Alcohol Rehabilitation. All offenders are told about the drug and alcohol rehabilitation programs available in the jail. If the offender expresses an interest in attending this program, this category is coded "1." The inmate is reminded that the D&A program might be less useful for him if he is not going to be at SPCS for at least a few weeks. If he is unsure of his legal status (e.g., he might be released the next day on bail), he is encouraged to wait to put in a request to attend D&A counseling.

PLACEMENT DECISIONS THAT ARE MADE AT SCREENING

Suicide

If an inmate is a potential danger to himself, the SCO should be notified and together the Intake Interviewer and the SCO can decide where to best house the inmate. The available options are:

- glass cell (or equivalent) for those inmates who are a serious suicide risk; the inmate will be under 24-hour camera surveillance as well as 15-minute checks by an officer
- segregation for those inmates who are a serious suicide risk; this option is available at all times, however, the glass cells should be the first choice for a suicidal inmate; if the glass cells are full, the inmate can be placed in segregation with 15-minute checks by an officer

- double bunking can be used in some cases for those inmates who are experiencing some suicidal ideation but no intent or those inmates who present as very depressed (but deny suicidality)

Mentally Disordered Offenders (MDO)

Inmates who are mentally disordered should be brought to the attention of the SCO and together with the Intake Interviewer the decision can be made about the most appropriate placement. The available options include:

- Segregation for those inmates who are seriously mentally disordered or who are mentally disordered and may be potential victims
- A specialized unit for those inmates who are mentally disordered but still able to function quite well or who have been in the jail many times before with no major difficulties
- If a specialized unit is full, another smaller unit may be used to house these inmates; the Living Unit Officer could also be notified that the inmate may be mentally disordered and may experience some difficulties

Violence

If an inmate poses a serious threat to the safety of other inmates (i.e., risk of violence), the SCO should be notified of this and together the Intake Interviewer can decide where this inmate would best be housed. The living unit officer can also be notified of the inmates potential for violence.

Victimization

If an inmate is socially awkward and may be a potential victim the SCO should be notified. This inmate could either be placed in another specialized unit. The living unit officer can also be notified that this inmate may be a potential victim.